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Update

Court rules insurer advocacy ads protected by First Amendment

NEW YORK—Television and print public service advertisements by the Insurance Information Institute blaming high liability insurance rates on the litigation explosion are protected under the First Amendment, according to a New York State Supreme Court judge.

In dismissing a false advertising suit against New York-based III on Aug. 3, Judge Kristin Booth Glen ruled the ads were not intended to promote sales. She did not rule on the veracity of the ads.

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Photo: AP/Wide World

Hurricane Elena hit the Gulf Coast in August 1985, causing $622 million in insured property damage.

Hurricanes

Complacency can be costly when winds howl

By MARK A. HOFMANN

A risk manager staring into the eye of a hurricane without a detailed catastrophe plan is courting disaster, risk managers and loss control consultants agree.

While a major hurricane has not buffeted the U.S. mainland since Hurricanes Elena and Gloria in 1985, risk managers in hurricane zones must be ready for the prospect of 150-mph winds and severe flooding each summer and fall, they say.

As this hurricane season unfolds, risk managers that do not have formal, written plans already in place can still take precautions, experts say, noting that it is better to have a partial plan in place than no plan at all.

"You must have a comprehensive disaster recovery plan, and you can't implement it at the time of the disaster," said Edward A. Pouzer, former risk manager for the city of Hartford, Conn., and currently a consultant with Betterley Risk Consultants in Worcester, Mass.

"People are always waiting till the last minute. They say, 'It's not going to happen to me,' " pointed out Jim Hanneman, president of Professional Safety & Management Consultants Inc. of Bradenton, Fla. "The basic thing is preparation."

"You've got to cover all bases," said Dave Goodwin of Dave Goodwin & Associates, a Surfside, Fla.-based risk management consultant, adding that "first base" is advance planning.

Denis A. Julien, director of risk management at Florida Progress Corp. in St. Petersburg, noted that a company faces a shortage of time, personnel and material resources when hit with a disaster like a hurricane. "There's nothing you can do about time, but advance planning can mitigate lack of personnel and material," he said.

Establishing a plan does not have to be a complicated process, said Ted Gebeau, manager of loss control engineering, property and casualty services for Kemper Group's national property/casualty companies in Long Grove, Ill. "It's a lot of common sense, really."

Risk managers have many resources to which to turn when assembling a plan, experts point out. For instance, property insurers like Industrial Risk Insurers can provide detailed checklists of procedures to follow before and after a hurricane strikes (see story, page 22).

Applying common sense to an uncommon situation starts with the emergency preparedness plan, experts say.

For example, Betterley's Mr. Pouzer said that when Hurricane Gloria struck the city of Hartford in September 1985, Hartford already had an emergency preparedness plan—albeit a generic one—in place. "I don't think we ever talked about hurricanes—but we were glad the plan was in place," Mr. Pouzer said.

Of course, every company and municipality faces unique exposures, said Kemper's Mr. Gebeau. As a result, Mr. Gebeau's department does not provide Kemper clients with a generic disaster plan, he said.

"There's no canned program—every building, every sit-

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Computers help forecast damages from hurricanes
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Devastating hurricanes would cripple insurers
Page 24

HMO rules to be eased by new law

By JERRY GEISEL

WASHINGTON—Landmark legislation designed to increase the competitiveness of federally qualified health maintenance organizations is nearing congressional approval.

Under legislation that would modify the Health Maintenance Organization Act of 1973, employers and federally qualified HMOs could negotiate rates based on an employer's own past and projected claims experience.

The legislation, now before a congressional conference committee, also would modify the so-called equal contribution rule, which requires employers to make the same contribution toward the premiums charged by federally qualified HMOs as they make toward their largest non-HMO plan.

The few differences between the legislation passed by the Senate on Aug. 11 and the House on Nov. 4, 1987, are expected to be resolved and the legislation enacted this year.

"This is legislation without enemies," said Janice Hand, a consultant with Hewitt Associates in Lincolnshire, Ill.

While employers have been battered in recent years by a barrage of benefit legislation enacted by Congress that has forced them to make constant and costly changes to their benefit programs, this is one piece of benefit legislation they welcome.

"We're thrilled that the legislation is on its way to a congressional conference committee. It addresses many of our concerns and will make HMOs more attractive to employers," said Carol Cronin, vp at the Washington Business Group on Health, a key backer of the legislation.

"The legislation goes a long way toward dealing with employer concerns about HMOs. The legislation will be well received by employers," said Gino Nalli, a consultant with The Wyatt Co. in Washington.

"The legislation will bring HMOs in line with the demands

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California dumps Royal Globe rule

By STACY ADLER

SAN FRANCISCO—Liability insurance premiums could be reduced in California following a state Supreme Court ruling last week that virtually wipes out the right of injured people to sue someone else's insurer for bad faith.

Almost a decade after its precedential ruling in *Royal Globe Insurance Co. vs. Superior Court*, allowing plaintiffs in personal injury cases to sue a defendant's insurer for bad faith, the California Supreme Court late last week reversed itself. A more conservative court said the 1979 Royal Globe doctrine has resulted in "escalating insurance costs to the general public resulting from insurers' increased expenditures to fund coerced settlements, excessive jury awards and increased attorney fees."

As a result of last week's court ruling in *Parvaneh Moradi-Shalal vs. Fireman's Fund Insurance Cos.*, an estimated 4,000 to 5,000 bad faith insurance cases filed annually in California in recent years will be barred, saving insurers millions of dollars in legal expenses.

Under the Aug. 18 ruling, plaintiffs in personal injury cases in California no longer have a statutory cause of action to sue defendants' insurers charging failure to settle or improper handling of a claim.

Claimants no longer will be able to "take two bites out of the same apple" by suing the policyholder and the policyholder's insurer, said N. Douglas Martin Jr., vp and counsel for Fireman's Fund Insurance Cos. of Novato, Calif.

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Update

Insurer advocacy ads protected

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III sponsored the ads throughout 1986 in national magazines, on network television and in the Sunday supplement sections of more than 200 newspapers nationwide.

The suit was filed in September 1986 by the New York Public Interest Research Group Inc. and three plaintiffs in personal injury suits. NYPIRG, a non-profit consumer advocacy organization, intends to appeal the decision.

Pfizer drops reinsurance suit

JEFFERSON CITY, Mo.—Pfizer Inc. has withdrawn a lawsuit against reinsurers of the defunct Transit Casualty Co. following a Missouri judge's threat to find Pfizer in contempt of court for interfering with Transit's liquidation.

Pfizer—a New York-based pharmaceutical concern insured by Transit from 1979 to 1985—sued Munich Reinsurance Co. and several others last year in Cook County Circuit Court in Chicago, seeking to collect claims directly from Munich Re and other Transit reinsurers (*BI*, Jan. 4).

Pfizer voluntarily withdrew its claims against Munich Re on Aug. 3, and on Aug. 12 withdrew the remaining charges against H.S. Weavers (Underwriting) Agencies Ltd., which underwrote reinsurance for Transit; two Weavers affiliates; and National Underwriting Agency Inc. of Chicago, a Transit managing general agent.

Judge Byron Kinder of the Circuit Court of Cole County, Mo., ruled Aug. 4 that Pfizer must withdraw its complaint or face a contempt ruling for interfering with the Missouri Insurance Division's efforts to liquidate Transit.

Pfizer attorney Thomas D. Rosenwein, who is with Schaefer & Rosenwein in Chicago, said the company will ask Judge Kinder to consider whether claims against the Weavers entities and NUA —not themselves reinsurers of Transit—represent interference.

BC/BS saved $6 billion: Study

WASHINGTON—Cost-containment efforts and an indirect benefit from strict Medicare payment policies saved Blue Cross & Blue Shield Assn. plans more than $6 billion in hospital bills over a 39-month period, a study shows.

Cost containment measures by BC/BS plans saved $4.8 billion in hospital payments while the indirect benefit of Medicare payment reforms saved the plans an additional $1.3 billion from Oct. 1, 1983 through year-end 1986, the study showed. These savings were attributed primarily to reduced hospital admissions.

However, these savings did not prevent an almost $2 billion loss in 1987 among member Blues plans (*BI*, Aug. 15).

Medicare payment reforms that since 1983 have required fixed payments for Medicare beneficiaries' inpatient care based on each patient's diagnosis and anticipated treatment have changed the way hospitals do business on a whole, resulting in a further reduction of hospital admissions for private payers, the study noted.

The study, which was funded by the federal Health Care Financing Administration, only addressed costs of inpatient hospital care.

2 Piper claims to be paid

LONDON—Insurance claims will be paid this week in the London market to two of the four owners of the North Sea oil platform that exploded in July (*BI*, July 11).

Lloyd's of London syndicates and members of the Institute of London Underwriters will pay $154.6 million to cover their share of the physical damage loss for two of the owners of the Piper Alpha platform—each with a 20% ownership.

A claim payment of 43.5 million pounds ($74.4 million) will be paid to Thomson North Sea Ltd.'s broker Willis Faber P.L.C. by tomorrow. The payment will include 18.5 million pounds ($31.6 million) from ILU members and 25 million pounds ($42.8 million) from syndicates at Lloyd's.

And, $80.2 million—$23.2 million from ILU members and $57 million from Lloyd's syndicates—will be paid to Union Texas Petroleum Ltd.'s broker, Alexander Howden Ltd., by Wednesday.

The two companies also have insurance with other underwriters.

Claims from the $790 million platform's two other owners have yet to be filed in the London market, said John Turner, deputy managing director of the Willis Faber oil and gas division.

Texaco Britain Ltd., which owned a 23.5% stake in Piper Alpha, is still negotiating with its loss adjuster, while Occidental Petroleum (Caledonia) Ltd., which owned 36.5% of the platform, is involved in discussions with Bermuda-based OIL Insurance Ltd.

Raymark free to sue attorneys

WICHITA, Kan.—A U.S. District Court judge has refused to dismiss Raymark Industries Inc.'s suit against two attorneys charging civil fraud and violation of the federal Racketeer-Influenced and Corrupt Organizations Act in representing asbestos plaintiffs.

The suit seeks the return of about $15 million Raymark paid out to 5,000 workers allegedly injured by asbestos, as well as unspecified damages from the workers' attorneys, Gordon A. Stemple of Los Angeles and Richard F. Gerry of San Diego.

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Errors & omissions

- Brian J. Waters is an executive vp of J.J. Negley Associates Inc. His title was incorrectly reported in the directory of surplus lines wholesalers in the Aug. 8 issue.

- The Greek law implementing the European Community's product liability directive limits awards to 7.2 billion drachmas ($47.4 million). A story in the July 11 issue said none of the laws so far passed that implement the directive contain liability limits.

Public policy can't negate contract language: Court

By STACY ADLER

TRENTON, N.J.—New Jersey's public policy to preserve the environment does not override an insurance policy exclusion that denies a policyholder indemnification for the cost of cleaning up hazardous waste on its own property, says a state appellate court.

In a decision overturning a controversial lower court ruling, the New Jersey Appellate Division late last month ruled that insurance policy language clearly prohibits real estate developer Summit Associates Inc. from recovering the cost of cleaning up its own property—regardless of the state's public policy—unless the waste posed an immediate threat to third parties.

While public policy may set the stage for a policyholder's claim, "it cannot alter clear provisions of a contract" between the policyholder and its insurer, the appellate court ruled.

The July 29 decision overturns a 1987 decision by trial court Judge Joseph E. Sadofski, who ruled: "The health, safety and welfare of the people of this state must outweigh the express provisions of the insurance policy" (*BI*, April 27, 1987).

The case involves a coverage dispute between Edison, N.J.-based Summit Associates and Liberty Mutual Fire Insurance Co. of Boston, which wrote a special multiperil policy for Summit.

Summit sought coverage for the cost of cleaning up pollution on a tract of land it had purchased from Edison Township, N.J.

Unknown to Summit when it purchased the land, the remains of an old sewage treatment facility were buried on the property.

During the construction of a parking lot on the site in 1983, a noxious odor began permeating the air. Following numerous complaints from workers and nearby residents, state health officials examined the soil and found that dozens of toxic chemicals, which had been buried inside the sewage treatment plant, were being released.

The state of New Jersey ordered Summit to remove the hazardous substances. Summit spent $438,599 to remove approximately 2,000 tons of sludge and 50,000 gallons of liquid waste from the site in July 1983.

Liberty Mutual denied coverage for the cleanup costs on the basis of the owned-property exclusion and the pollution exclusion in Summit's multiperil policy.

However, the trial court ordered Liberty Mutual to indemnify Summit, saying that the state's public policy for preserving the environment outweighed the insurance policy exclusions.

However, during Liberty Mutual's appeal, no party in the case—Summit, Liberty Mutual or any party that filed amicus curiae briefs—argued that public policy considerations should override the language of an insurance policy.

"I don't think any reputable policyholder would argue that public policy should obliterate contract

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BI to list loss control consultants

The Oct. 10 issue of *Business Insurance* will contain the second annual directory of property loss control consultants, published in conjunction with a Spotlight Report focusing on specialty risks.

Insurance companies, brokers and independent companies that provide loss prevention inspections, building plan reviews, loss prevention research, training seminars and other loss control consulting services to companies, institutions and government entities are eligible to be listed. Loss control services must be provided on a fee-for-service basis.

The directory is published as an editorial service; there is no charge to be included. However, loss control consultants must request, fill out and return a *Business Insurance* questionnaire by Sept. 12 to be listed.

If you provide property loss control consulting or engineering services and you have not yet received a questionnaire, you may request one by writing Christine Woolsey, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; or by calling 312-649-5460.

Initiative funding blocked by judge

By STACY ADLER

LOS ANGELES—State Farm Mutual Automobile Insurance Co. must stop contributing to a statewide, insurance industry-sponsored campaign to bring no-fault auto insurance to California, a state court judge ruled last week.

The temporary restraining order was granted last Thursday in class-action litigation brought on behalf of State Farm policyholders charging that the insurer is violating policyholders' First Amendment guarantees of free speech by using policyholder funds to participate in political campaigns that they may not support.

The suit also contends the company conducted unfair and misleading business practices and breached its fiduciary duty by using its policyholder surplus to promote the insurer-sponsored initiative on the November ballot in California.

However, a spokesman for State Farm said, "State Farm not only has the First Amendment right, but the obligation to take part in political processes that affect policyholders. It is entirely legitimate for State Farm to be involved in the legislative process."

A hearing on the temporary restraining order and other issues raised by the suit will be held Friday.

The order by Los Angeles County Superior Court Judge Barnet Cooperman prohibits State Farm from making any additional contributions to the Insurance Industry Initiative Campaign Committee, the group sponsoring the no-fault measure.

However, the order does not stop the committee from using money it has already received from State Farm nor did the judge order the committee to return the money contributed by State Farm, as requested by the suit.

The insurance industry committee has announced it will spend some $43 million to win approval of the no-fault initiative, Proposition 104, and to fight three consumer-sponsored initiatives that would limit or roll back auto insurance rates (*BI*, Aug. 1).

According to the lawsuit, "the $43 million is nearly seven times greater than the largest amount ever spent on one side of an initia-

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Inside

- A public interest group in California sues to force the state to clean up the backlog of stalled workers compensation cases. **PAGE 4**
- Corporations should encourage healthy lifestyles through positive programs rather than discriminatory and destructive policies, says this week's editorial. **PAGE 8**
- Public entity risk managers change their professional group's name. **PAGE 12**
- Three university teaching hospitals form an offshore captive insurance company. **PAGE 17**
- With the recent expansion of Medicare, Joseph W. Duva, director of employee benefits at Allied-Signal Inc., examines whether employers still need to provide supplements to Medicare coverage. **PAGE 19**
- A toy company's insurer has reached a settlement valued at $7.5 million with the parents of child who was struck by a car while riding a tricycle manufactured by the company. **PAGE 29.**
- Second-quarter results for brokers portray steadily deteriorating premium rates in commercial lines of insurance, says Leonard M. Wilson, senior vp of Lazard Asset Management Inc. **PAGE 31**

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BI broadens eligibility for annual award

A new type of risk manager is eligible to win the 1989 *Business Insurance* Risk Manager of the Year Award or to be elected to the Risk Management Honor Roll.

For the first time, administrators and executive directors of self-insurance funds and pools are eligible to be nominated for the award.

Previously, the award was limited to risk managers for corporations, financial institutions, individual government entities, and tax-exempt or not-for-profit institutions.

"We want to recognize the contributions to risk management that the administrators and executive directors of self-insurance funds and pools make," said Kathryn J. McIntyre, associate publisher and editor of *Business Insurance*. "We do not, however, believe that the risk management accomplishments of a person managing a pool or fund for multiple members can be compared with the accomplishments of a risk manager for a single government entity.

"Therefore, we created a new category," she explained.

The 1989 Risk Manager of the Year and Risk Management Honor Roll will be announced in the April 9, 1989, issue of *Business Insurance*, which will coincide with the 27th annual Risk & Insurance Management Society conference in Atlanta.

Nomination forms for the 1989 competition are now available.

Each year, candidates for the Risk Manager of the Year Award are scored on 10 specific criteria by a panel of 10 independent judges (see story, page 27).



Photo: Mike Marcotte

The judging panel includes past recipients of the award and members of previous years' Risk Management Honor Roll, top executives of insurance companies and insurance brokerages, a consultant and a risk management academician.

The names of the judges that will select the 1989 Risk Manager of the Year will be announced next month.

While only one candidate will be named Risk Manager of the Year, as many as five others can be named to the Risk Management Honor Roll, which was established in 1980 to recognize risk management achievements in different types of employment settings.

The highest scoring candidate is selected as the Risk Manager of the Year. And, starting with the 1981 competition, the remaining candidates have been separated by employment categories: corporations with sales exceeding $300 million; corporations with sales less than $300 million; government entities; and tax-exempt or not-for-profit institutions.

A fifth category was added in 1985 to recognize achievement by risk managers employed by financial institutions.

According to the rules of the competition, the employment category represented by the Risk Manager of the Year is eliminated. Then, in each of the remaining categories, the highest-scoring candidate is named to the Risk Management Honor Roll, at the discretion of the judges.

A candidate need not spend full time handling risk management, but must be a full-time employee of the organization for which he or she directs the risk management program.

A candidate can be nominated by anyone familiar with the risk management professional's work. For example, any employee or group of employees can nominate the organization's risk manager; a broker, consultant or other service supplier can nominate a client; and a risk manager can nominate a colleague.

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Nicolet exhausts asbestos cover, to be liquidated

By STACY ADLER

PHILADELPHIA—Asbestos producer Nicolet Inc. will be liquidated as the result of the overwhelming number of asbestos bodily injury and property damage claims it faces.

Nicolet, which filed for reorganization under Chapter 11 of the Federal Bankruptcy Act on July 17, 1987, has no insurance remaining to pay the more than 61,000 asbestos claims filed against it.

As a result, the company July 25 filed a plan for dissolution under which all the company's assets will be sold and the proceeds placed in a fund to pay asbestos claims.

Nicolet is at least the third company to liquidate because of asbestos litigation (*BI*, Dec. 21, 1987).

Earlier this year, Brunswick Fabricators Inc., a small fabricator of asbestos cement board in Philadelphia, was forced into liquidation. Brunswick only faced about 100 asbestos bodily injury claims, but had no liability insurance, explained Philadelphia attorney Jim Hartz, who represented the company in its bankruptcy proceedings.

Brunswick, which had about $1 million in annual sales, was a "longtime customer" of Nicolet, said Mr. Hartz. Brunswick bought asbestos-containing boards from Nicolet, as well other asbestos producers, and cut them into various shapes.

In addition, 48 Insulations Inc., a large asbestos producer in Aurora, Ill., that filed for bankruptcy in April 1985, is out of business, explained Sarah Stegemoeller, the attorney representing creditors in the bankruptcy.

While Nicolet's liquidation plan of reorganization calls for dissolution of the company, 48 Insulation's liquidation plan of reorgani-

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AHA recommends methods to cover uninsured workers

By BRIGITTE MAXEY

Small employers should band together to increase their health insurance buying power, and insurers should develop new products tailored to small businesses to provide basic coverage for more U.S. workers, the American Hospital Assn. recommends.

Although the workplace is the most common source of health insurance for the non-elderly in the United States, 75% of the 34.8 million uninsured are employed or are dependents of those employed, reports a recent AHA study.

Low-salaried workers often are not offered health insurance because the employer's share of the premium would significantly increase the employees' total compensation, according to the study, titled "Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage."

Among the other reasons for the large number of uninsured U.S. workers are employees' inability to meet eligibility requirements and employee rejection of the coverage, often because it is unaffordable, according to Irene Fraser, senior staff specialist at the AHA in Chicago.

"This study is a very strong argument for trying to facilitate methods to increase group size and use of high-risk pools so people that are excluded (uninsured) can still have access to health insurance coverage," Ms. Fraser said.

To reduce the numbers of uninsured workers, Ms. Fraser proposed five approaches for employers and insurers:

- Forming new large groups of subscribers. This would maximize opportunities for the uninsured to obtain insurance by creating multiple-employer plans, employee leasing, statewide pools or requiring employers to provide coverage.

In multiple-employer plans, two or more employers are grouped together through a central organizer or trustee. This trustee obtains the master insurance policy and the individual enrollees deal with the trustee rather than the insurer.

Under employee leasing, the client company officially fires his/her employees, who are then rehired by the "leasing" or "contract staffing" firm, and leased back to the original client. The leasing company administers all employee benefits.

The report points out that states can create high-risk pools for "medically uninsurable" individuals as well as create general-eligibility pools, which could include employer groups.

In addition, the federal government or state governments could require employers to offer health insurance.

For example, a Massachusetts law approved this spring mandates that employers provide health care coverage benefits of $1,680 per employee annually or pay a "medical security contribution" tax (*BI*, May 2).

- Ease restrictions on group health care plans to allow more people to qualify. This can be done by widening eligibility requirements for ongoing public and private programs.

The study specifically recommends expanding Medicaid eligibility to those whose incomes currently disqualify them from the program but do not have enough cash to purchase coverage on their own. It also advocates coverage for part-time employees.

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Risk managers assume more duties

By KAREN HUELSMAN

Computers increasingly are becoming a fact of life for risk managers, according to a recent survey.

More risk managers at companies of every size are turning to risk management information systems, according to the seventh annual "Risk Management Compensation Survey" by Logic Associates Inc., a New York-based recruiting firm.

And, as part of the trend toward broadening risk management duties, more risk managers are responsible for computer data security companywide, according to the survey.

The survey also found that more risk managers also took direct responsibility for safety and fire loss control engineering in 1987.

"Data security, safety and loss control are all gravitating under the risk manager's umbrella," said Richard Meyers, executive vp with Logic.

Logic Associates received responses from 1,144 risk managers to its 1987 survey and found many of the trends of the mid-1980s still in full swing.

The increase in use of computers, for example, remains steady.

Logic Executive Vp Bill Perry predicts that 80% to 90% of risk management departments eventually will use computerized information systems. "We get more and more calls asking for people who are computer literate," he said.

In the smallest companies, those with $200 million or less in annual sales, 29% of the risk managers had an RMIS, up from 26% the year before.

Generally, as company size increased, risk managers were more likely to have access to an RMIS.

Almost half of the respondents, 49%, from companies with $201 million to $500 million in sales had computer systems, up from 46% in 1986.

A slightly smaller percentage, 43%, of risk managers at companies with $501 million to $1 billion in sales had an RMIS, up from 41% in 1986.

A majority of risk managers working at companies in the four largest sales categories reported they had access to computerized information systems.

At companies with $1 billion to $2 billion in sales, 63% of the risk managers had an RMIS, compared with 61% in the previous survey.

Risk managers at 77% of the companies in the $2 billion to $4 billion sales category reported they had access to an RMIS, up from 73% in the previous survey.

Some 60% of the risk managers at companies with $4 billion to $7 billion in annual sales had an RMIS, up from 56% the year before.

The largest companies, those with more than $7 billion in annual sales, were most likely to have an

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Risk managers' areas of responsibility

(By company sales in millions of dollars)

	0-$200	$200-$500	$500-$1,000	$1,000-$2,000	$2,000-$4,000	$4,000-$7,000	More than $7,000
Risk financing	63% / 16%	71% / 19%	61% / 15%	68% / 11%	62% / 12%	75% / 13%	44% / 17%
Negotiation of coverage placement	75% / 20%	62% / 25%	72% / 18%	73% / 12%	65% / 14%	68% / 16%	41% / 17%
Claims handling	73% / 20%	58% / 26%	65% / 28%	42% / 37%	38% / 51%	35% / 49%	24% / 37%
Safety/fire loss engineering	64% / 29%	65% / 22%	43% / 28%	36% / 39%	24% / 53%	27% / 57%	17% / 40%
Data security	63% / 21%	20% / 47%	17% / 28%	8% / 37%	7% / 39%	10% / 47%	3% / 27%
Benefits administration	64% / 24%	37% / 27%	13% / 24%	18% / 21%	7% / 27%	2% / 25%	8% / 38%
Pension/profit sharing administration	31% / 27%	32% / 32%	15% / 7%	15% / 13%	5% / 22%	5% / 6%	0% / 29%

Direct, hands-on responsibility / Supervisory/advisory responsibility

Source: Logic Associates

Chart: Amy Palmer

California suit hits work comp backlog

By GLENN HUNTLEY

SACRAMENTO, Calif.—Three workers compensation claimants are seeking to force California state officials to spend about $11 million annually to clear up a backlog of workers compensation cases.

The funds should be used to hire 50 administrative judges and support staff to help handle the more than 200,000 workers comp cases that are pending at any one time, according to the suit filed on behalf of the claimants by California Rural Legal Assistance Inc., a public interest law firm in San Francisco.

About 11%, or 27,314, of the 245,665 new work comp claims filed in 1987 in California were contested, according to the California Workers Compensation Institute.

But, of those contested claims, approximately 86%, or 23,490, were not scheduled for hearing within the 30-day limit set by state law. In addition, decisions are not being issued within the 30-day period following the hearings—another requirement of state law, the suit charges.

And, in 1986 it took an average of 25 months to resolve a contested case after the worker applied for a hearing, according to the institute.

The Compensation Appeals Board and Gov. George Deukmejian have been in "gross violation of these requirements and have been in violation for several years," according to the lawsuit.

The suit, filed July 28 in California Superior Court in Sacramento, names Gov. Deukmejian, Director of Industrial Relations Ronald Rinaldi, Workers Compensation Appeals Board Chairman C. Gordon Taylor and other state officials.

Both employee and employer suffer when delays keep a worker off the job or away from needed rehabilitation, said Art Azevedo, attorney for the three plaintiffs.

The backlog of appeals has increased in the last three to four years, he said.

The lawsuit contends that a delay "often exacerbates an injured worker's medical condition and therefore imposes increased costs on insurers and employers."

Gov. Deukmejian has vetoed funding for additional workers compensation judges several times, most recently last year, according to the suit.

Californians for Compensation Reform, a broad-based coalition of employer groups that has sought workers compensation reform for several years, would not comment on the lawsuit.

A bill aimed at increasing work comp benefits and speeding payments without imposing new burdens on employers has been under review since April by a legislative conference committee that has been meeting with labor, employers, insurers and a state commission (*BI*, April 11). However, it is doubtful that legislation to overhaul the California workers compensation system, the largest in the country, will be passed during this legislative session, which ends Aug. 30 (see story page 29).

Gov. Deukmejian remains committed to changes in the workers comp system even if legislation is not passed this year, Mr. Rinaldi said. "We believe that the entire system needs reform."

The need for reform is particularly reflected in the escalation in workers compensation premiums paid by employers, Mr. Rinaldi said. Direct written premiums totaled $6.4 billion in 1987, up 21% from the $5.3 billion paid in 1986.

The California Workers Compensation Institute estimates workers comp premium volume in California could reach $7 billion this year.

Total benefits paid in the state in 1985 were $3.24 billion, the highest in the nation, compared with $1.56 billion paid in second-place Texas, the workers compensation institute reported.

But benefits in California are low compared with other states, according to the institute. The current maximum temporary disability benefit of $224 a week in California is lower than that in 42 other states.

The number of unresolved workers compensation cases is so voluminous in California that the lawsuit, quoting state statistics, refers to them in terms of file space.

"Delay and inefficiency are so pervasive and inadequate personnel resources so meager that defendants publish an official data series which reveals the number of 'inches of unprocessed mail,' " according to the suit.

In the Los Angeles office alone, the volume of unprocessed case files totaled 4,618 inches, or 384 feet. In the Van Nuys office, a northern Los Angeles office, the files amounted to more than 78 feet, the lawsuit contends.

Meanwhile, the delays have forced many injured workers who may have settled their claims earlier to seek legal help, said Mr. Azevedo of CRLA.

"The system has atrophied," Mr. Azevedo said. Besides the long waiting period for hearings, some workers that have claims as serious as advanced cancers cannot get more than a two-hour hearing before a workers compensation judge, which Mr. Azevedo called terribly inadequate.

However, Mr. Rinaldi of the state industrial relations department said injured workers are not suffering as a result of delays in contested cases.

"It's certainly not my perception that people are running around without benefits," Mr. Rinaldi said.

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EMPLOYEE BENEFITS BULLETIN:
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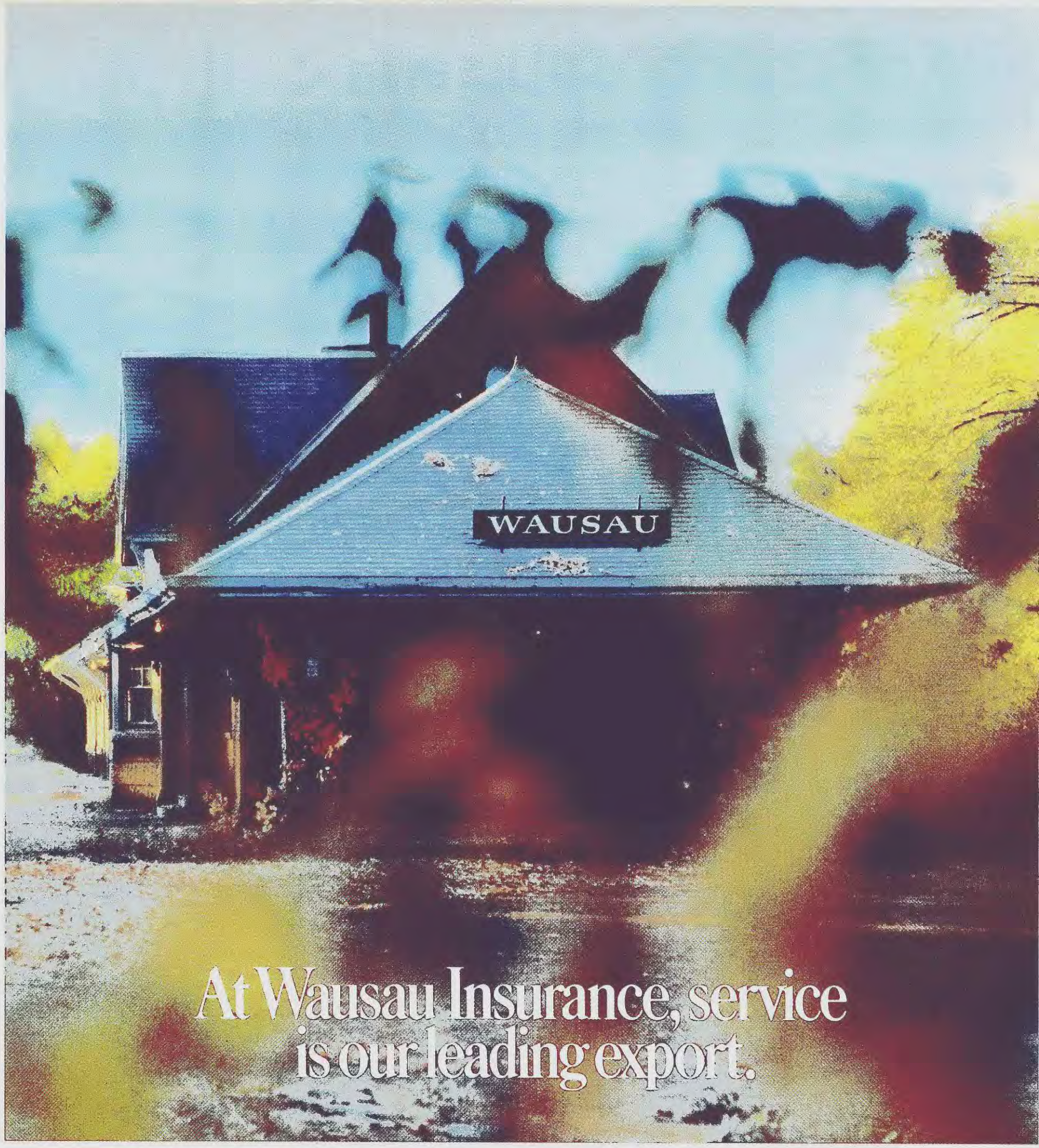
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Quaker changes retiree health plan

By GLENN HUNTLEY

Quaker Oats Co. will deposit funds into special accounts for new retirees, based on their length of service, to help the retirees pay for uncovered medical expenses and health plan contributions.

In addition, under a plan to be implemented Jan. 1, the company will discount new retirees' contributions toward their health care benefits, also based on their length of service.

Under the program, which only applies to retirees after Jan. 1, Quaker Oats will deposit $12 into the accounts for each year of an employee's service with the company.

For example, retired employees with 10 years of service will receive $120 per year, while retirees with 40 years' service will receive $480 annually.

The funds in the accounts can be used to pay premiums, deductibles and other out-of-pocket expenses under Quaker Oats' self-insured indemnity plan, which covers both retirees and active employees, explained a spokesman for the Chicago-based food products and toy producer.

Quaker Oats' health care plan, which is administered by The Prudential Life Insurance Co. of America in Newark, N.J., covers hospitalization, prescription drugs, psychiatric and hospice care, as well as dental, vision and hearing care.

Lifetime maximum coverage is $350,000 for all benefits except psychiatric and hospice care, which are $35,000 and $15,000, respectively.

Also under the plan, new retirees' monthly contributions to health care coverage will vary based on years of service and Medicare eligibility.

For example, new retirees with 10 years' service who are not eligible for Medicare will pay the most: $30 for individual coverage, $36 for spouse coverage and $10 for each dependent child.

Conversely, employees with 40 years of service who are Medicare recipients will pay the least: $2 for individual coverage, $4 for spouse coverage and $10 for each dependent child.

New retirees' contributions are frozen at those amounts until June 30, 1991, after which they can be adjusted annually. The increases, however, will be limited to 5% per year, according to a statement from the company.

Also under the new health incentive program, all Quaker Oats retirees after Jan. 1 will be subject to annual deductibles of $250 per family.

After the deductible, the plan will pay 85% of the next $4,500 in health care expenses for Medicare-eligible persons and 85% of the next $6,500 for non-Medicare-eligible retirees. The plan will pay 100% of subsequent expenses, up to the lifetime benefit limits.

Therefore, when the health incentive plan account contributions are applied, the maximum out-of-pocket health care expense for a retired Quaker Oats employee with 40 years of service who is eligible for Medicare will be $445, or $945 less the $480 in his or her health expense account.

In contrast, the maximum out-of-pocket expense for a 10-year company veteran who is not eligible for Medicare will be $1,105, or $1,225 less the $120 in his or her health expense account.

Benefit beat

TVA passes on costs

The Tennessee Valley Authority, one of the nation's largest electric utilities, is requiring about 5,000 managers and professional employees to pay their own Social Security taxes and contribute to their health benefit plans for the first time.

The Knoxville, Tenn.-based utility instituted the cost-shifting measures as part of a major reorganization plan that also includes a reducing the workforce by 20%, freezing top-level employees' salaries, selling the corporate jet and delaying a nuclear power project.

Beginning Oct. 1, TVA's managers will begin paying half of the 15.02% Social Security payroll tax that had been borne entirely by the utility. The tax usually is split evenly between employees and employers.

In addition, TVA management employees will be asked to contribute a portion of the premium for the company's employee health benefit plan, which includes major medical and dental coverage.

Previously, the TVA picked up the entire benefit tab for management employees, such as supervisors and professionals. The TVA's non-management employees currently pay 20% of their medical premium and 14% of dental premiums, said David Kiefer, TVA's employee benefits manager.

Mr. Kiefer would not identify TVA's health insurer because premiums and specific coverage limits are currently under negotiation, nor would he disclose how much management employees will have to contribute for their health benefits.

The reorganization plan is expected to produce a one-time $290 million savings for the TVA.

•

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Glenn Huntley, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 213-651-3710.



Samuel Byron named MOAC president

Samuel T. Byron Jr. has been appointed president and chief operating officer of Marine Office of America Corp. in New York, a unit of Continental Corp.

Mr. Byron joined MOAC in 1961. He was appointed vp and Eastern regional manager in New York in 1971, and Canadian regional manager in Toronto in 1975. He returned to New York in 1981 as senior vp and Atlantic regional manager.

Most recently, Mr. Byron was executive vp and chief operating officer of North American operations.

In other changes at Continental: **Kenneth B. Zeigler** appointed president of Continental International, part of Continental Corp.'s marine and international group, and **James R. Parkinson** appointed resident vp of Continental Insurance's Denver branch.

In other insurer changes:

John R. Pollock appointed president and chief operating officer of General Casualty Cos. in Sun Prairie, Wis.

Robert W. Patin joined Washington National Corp. in Evanston, Ill., as chairman and chief executive officer. Most recently, Mr. Patin was chairman and managing general partner of Harbor Group. He succeeds **Stanley P. Hutchison**, who is retiring but will continue as a director.

Roy Goldman promoted to vp and associate actuary of The Prudential Insurance Co. of America's group operations in Newark, N.J.

Comings & goings: industry

Charles Mitchell joined C.E. Heath Compensation & Liability Insurance Co. in San Francisco as executive vp-risk management. Most recently, Mr. Mitchell was vp-loss control for Citation Insurance Co.

Fred Fontein and **Richard G. Marose** promoted to vps of The Home Insurance Co. in New York.

Ralph M. White named vp at Reliance Insurance Co. in Philadelphia.

William L. Finley named chairman of the State Compensation Fund in Phoenix, Ariz.

Marcus Hildmann appointed president and chief executive officer of Allianz Insurance Co. and Allianz Underwriters Insurance Co. in Los Angeles.

Ronald Berler named vp and managing director-international operations of Industrial Risk Insurers in Hartford, Conn.

Reinsurance

Trenwick America Reinsurance Co., the Stamford, Conn.-based reinsurance underwriting unit of Trenwick Group Inc., promoted the following employees to senior vp and director: **Stephen H. Binet, Jacques Q. Bonneau, John P. Britton, Paul Feldsher, Barbara R. Freed, Robert A. Giambo, Alan L. Hunte, Michael F. Mather, Robert L. Nason** and **Peter C. Thomas.** Mr. Hunte also is treasurer. All had been vps. The promotions were part of the restructuring that followed the June resignations of Trenwick Group President **Angus Robinson** and Executive Vp **Mark W. Hinkley**. Both had been directors and founders of the company.

Karl J. Mayr named senior vp-treaty marketing/underwriting at Frankona Reinsurance Co.'s U.S. branch in Kansas City, Mo.

Dennis B. Zettervall named president of Hartford Re Management Co. in Hartford, Conn., a unit of Hartford Insurance Group.

Stephen E. Malone joined Hitz & Associates Inc. in Minneapolis as vp. Previously, Mr. Malone was a senior vp with MRM Inc. in New York, a unit of E.W. Blanch Co.

Leonard S. Johnsen joined the reinsurance division of Smyth, Sanford & Gerard in New York as senior vp-domestic treaty. Previously, Mr. Johnsen was a vp with John P. Woods Co. Inc.

Steven J. Bensinger, chief financial officer of Skandia America Group in New York, will assume the additional role of executive vp.

HMO/PPO

Ted LaBedz appointed chief executive officer and president of health maintenance organization Share Health Plan in Minneapolis, effective Oct. 1. Mr. LaBedz is currently chief executive officer of Physicians Health Plan of Northern Indiana, an HMO.

Wayne R. Moon promoted to executive vp and manager of operations of Kaiser Foundation Health Plan Inc. in Oakland, Calif.

Other suppliers

Marsh L. Ballard named president and chief executive officer of Chicago-based Parkside Health Management Corp., a health care management service.

Richard D. Pearson, named manager of the Milwaukee office of TPF&C, a division of Towers, Perrin, Forster & Crosby Inc.

Joseph Talbert promoted to senior vp of The FPE Group in St. Charles, Ill., a loss control consulting firm.

Thomas C. Ramey named president and chief executive officer of Jurgovan & Blair Inc. in Potomac, Md., a managed health care consultant and subsidiary of American International Group Inc.

Brokers

Charles D. Warren joined Frank B. Hall & Co. of Louisiana Inc. in New Orleans as chief executive officer. Mr. Warren had been regional sales director of Alexander & Alexander Inc. in Houston.

Thomas G. Hardy Jr. named president and chief executive officer of Frank B. Hall & Co. Inc. of Texas in Dallas, a newly created position.

Edwin C. Scheurer appointed vice chairman at Frank B. Hall & Co. of New York Inc., a subsidiary of Frank B. Hall & Co. Inc.

Ronald Wilson named senior vp of Johnson & Higgins in Los Angeles.

James A. Kelch appointed president of Wellington-Ross Insurance Services in San Francisco, an ABI Management Inc. unit.

McDonough Caperton Insurance Group in Charleston, W.Va., promoted the following to senior vp: **Jerry Breisinger** in Pittsburgh; **Pete Gibson** in Lexington, Ky; **Claudia Lindsey** in Charleston, W.Va.; **Nick Sparachane** in Wheeling, W.Va.

Stewart W. McDowell joined Collier Cobb & Associates Inc. in Charlotte, N.C., as vp-surety. Previously, Mr. McDowell was surety zone manager for Chubb Corp. ■

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Opinions

Circle K rights a wrong

WE ARE ALL FOR employers promoting healthy lifestyles among employees, but by using a carrot, not a stick.

That is why we were relieved that Circle K Corp. of Phoenix, Ariz., this month suspended its policy of excluding health care plan coverage for illnesses and accidents that it determined were due to "lifestyle" choices by its employees (*BI*, Aug. 15).

Among the exclusions were to be AIDS claims, except when the disease was contracted through blood transfusions. The policy also would have excluded treatment for illnesses and accidents associated with drug and alcohol abuse, though the plan was to continue to cover rehabilitation costs.

Circle K's stated objective: to reduce costs by excluding coverage for illnesses and accidents that in its judgment could have been avoided if employees had acted properly. It also wanted to send a message to homosexuals and substance abusers that they should not work for the company.

Thankfully, Circle K never had occasion to consider a claim denial under this policy.

Eliminating health care benefits because the employee could have avoided the accident or illness reminds us of the days—until Congress barred the practice—when employers routinely provided reduced health care benefits for pregnancy because women chose to get pregnant.

And, while Circle K management obviously believes that it makes perfect sense to exclude coverage for illness and accidents associated with AIDS and substance abuse because they can be avoided, this reasoning can be carried to even greater extremes. How about excluding coverage for people who are overweight if the weight problem aggravates their illness, or for people who drive to work who are involved in a car accident if they could have taken public transportation?

Circle K also intended to consider whether to extend coverage to a so-called lifestyle-related health care claim on a case-by-case. The criteria used under this circumstance could be applied differently from employee to employee.

Special exclusions in health care plans based on a corporate management's beliefs on what is and what is not a healthy lifestyle are unfair. Yes, employers often are paying the bulk of the premium for the coverage, but they also are receiving a tax deduction for the cost.

Group health insurance coverage also is a form of compensation, as employers have been eager to stress in recent years. Just as employers cannot tell employees how to spend their paychecks, they should not be able to deny employees needed health care coverage for illnesses or injuries that in the employers' judgment could have been avoided.



Of course, we do not advocate entitlement to coverage for elective treatments, like cosmetic surgery to lift bags under the eyes. We do believe a group health plan must provide employees with the means to pay for necessary medical care for injury and illness without suffering financial ruin. Plans subject to these special exclusions for certain types of behavior will not fulfill the purpose.

Furthermore, a policy like Circle K's is doomed to fail in controlling health care costs because doctors and hospitals can code the treatment reports differently to exclude any mention of AIDS, alcohol or drug abuse. The policy would drive the real cause of illness and injury underground.

Any employer seeking to reduce its health plan costs associated with lifestyle behavior is far wiser to promote education campaigns on AIDS and alcohol and drug abuse. A well-designed and funded employee assistance program for employees to turn to for help with substance abuse problems also would do more to control health care costs.

We commend Circle K for suspending the policy in the face of widespread criticism and hope that upon further consideration its management will seek to encourage healthy lifestyles through positive programs rather than discriminatory and destructive policies.

Letters

Insurance industry needs fresh scrutiny

To the editor: Perhaps it is time for risk managers to ask ourselves whether we have any business taking side publicly in litigation over what may be a Robinson-Patman violation (*BI*, Aug. 8).

Whether there was a refusal by the insurance industry to perform its function is a legitimate issue for state attorneys general to contest in federal court. We weren't there. We don't know what was said or done. There is not one of us who ever bought coverage for his or her company who has not felt the sting of "bad facts making bad law."

I'm not prejudicing the case, but I'm enough of a student to know that the McCarran-Ferguson Act was the result of an intense industry lobbying effort following the Southeastern Underwriters Assn. case, when the industry was caught clearly in a massive antitrust violation. Dick Heydinger, president of the Risk & Insurance Management Society, knows that every bit as well as I do.

Suffice it to say the world has changed since McCarran-Ferguson was passed in 1945. Certainly Congress is taking a fresh look at an industry that was an $80 billion negative taxpayer through a 10-year stretch to the mid-1980s. It would be irresponsible of Congress not to. The insurance industry is not of the cottage or developmental variety. It is not on the endangered species list and the repeal of McCarran-Ferguson won't put it there.

It was all too comfortable to be able to get big reputations when taxpayers supported our cost of risk budgets, but those of us who are left have proven we can accomplish our tasks in difficult times.

The insurance mechanism doesn't need to be an antitrust vehicle or a tax scam in order for us to further our careers. Let the insurers tote their own water.

Robert J. Field
Corporate Risk and Benefit Manager
Gilmore Enterprises Corp.
Kalamazoo, Mich.

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Insurer defense costs passed to consumers

To the editor: The article on the front of your Aug. 8 issue covering J. Robert Hunter's presence at the Assn. of Trial Lawyers of America national convention, "Activists Declare War on Insurers," led me to question who are the members of the National Insurance Consumer Organization that Mr. Hunter purports to represent. Are these the same insurance consumers who will be forced to foot the insurance companies' defense bills for

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Letters

Continued from page 8

West Virginia Attorney General Charles Brown's "nuclear attack," or the potential flood of lawsuits that would occur should every declination of coverage qualify for legal action?

I recognize the perception that the insurance industry is a monolithic "deep pocket," but unfortunately it's my $1,000 auto premiums and million-dollar company premiums that make up that deep pocket.

Any cost faced by the industry in the way of claims, administration or legal costs must ultimately be borne by the policyholders. Thus, ATLA's nuclear attack on the industry must ultimately result in higher costs for those insurance consumers that Mr. Hunter purports to represent.

That is not to indicate there aren't some problems with the system of insurance and that perhaps there are even a few crooks in the insurance industry.

I would maintain that without looking too hard, we could find a few crooks in ATLA and perhaps among us risk managers. Laser surgery may be in order, but not a nuclear holocaust.

I'm active in the Risk & Insurance Management Society and, as such, am somewhat biased. But, I feel that the significantly more balanced approach currently being taken by RIMS, as indicated in "RIMS Defends Value of Antitrust Immunity" (*BI*, Aug. 8), is a much more rational approach. Anyone who followed the RIMS "shoot out" with the insurance industry over the claims-made form can attest to the fact that we are not "in bed" with the industry. We are espousing adequate state regulation, consistency of contract form, continuation of advisory rate availability to small insurance companies, full implementation of the Risk Retention Act, etc.

None of these steps will result in the dismemberment of the industry but should result in the availability of a better regulated and more solvent insurance product.

Gerald L. Belfiglio
Director-Risk Management
Allegheny Ludlum Corp.
Pittsburgh

Market tightens for all insurers

To the editor: Your editorial "Cooler Heads" (*BI*, Aug. 8) failed to address a few salient points. When the market tightens it tightens for all. Surplus lines insurers with minimal net retentions become especially susceptible to the whims of the ultimate cash-flow underwriters: the reinsurers.

Furthermore, most surplus lines insurers are operating units of admitted insurers. When the parent mounts a drive for increased revenues, contributions might be expected from all quarters.

The editorial cartoon should have depicted a two-headed dog: the surplus lines head remaining complacent while the admitted market head rabidly chases its own tail. If the rabid head bites the tail, you can bet *both* heads are going to howl.

Arlon A. Chaffee
Associate Risk Manager
Tyco Laboratories Inc.
Exeter, N.H.

Nader has made big contributions

To the editor: What kind of American woodwork do people like risk manager/letter writer Peter Downes crawl out of—not to be aware of the tremendous contribution that my dear friend Ralph Nader has made, not only to the betterment of life in America but worldwide (*BI*, Aug. 15). I have shared platforms, lobbied in the American Senate and House, urged and tried to persuade American and European governments and have been very active with Mr. Nader in his many meaningful activities.

I have met a few big men—Eisenhower and Churchill—and Mr. Nader is very much one of them.

Mr. Downes' letter apparently follows a response to Mr. Nader's report on the Lloyd's Lime Street Mafia, not the least important aspect of which is the references to Lloyd's complete failure to introduce loss prevention and hazard identification techniques.

It cannot be much of a distance from Baltimore to Mr. Nader's Washington headquarters, so why doesn't Mr. Downes (assuming he has the inclination) do what many other people would do, phone Mr. Nader and see the tremendous work that he is doing, of which I am bitterly envious on this side of the pond.

James Tye
Director General
British Safety Council
London

HMO Act

Continued from page 1

of the marketplace. It adds needed flexibility," said Stuart Brahs, vp-federal affairs in the Washington office of The Principal Financial Group.

"This is a marvelous piece of legislation. It puts the whole business of price and premiums on the bargaining table," observed James Doherty, president and chief executive officer of the Washington-based Group Health Assn. of America.

The proposed changes to the HMO Act are intended to make federally qualified HMOs more competitive with non-qualified HMOs and other health care plans.

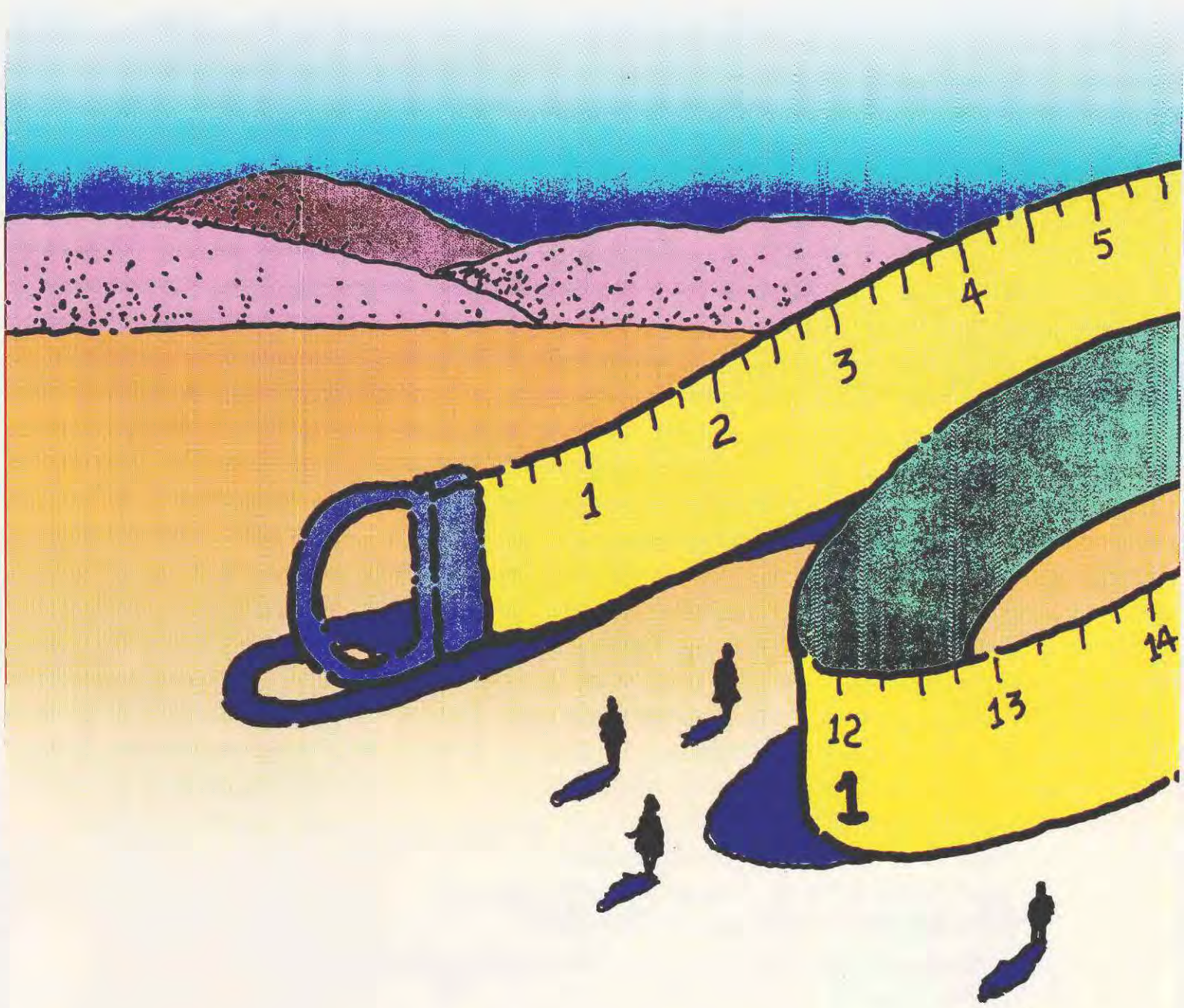
Non-federally qualified HMOs, which have been free to experience rate employers' plans and have not been saddled with other regulatory restrictions, have captured much of the recent HMO growth.

For example, during the first three months of this year, enrollment in non-federally qualified HMOs climbed 9.9% compared with a 4.9% gain for federally qualified HMOs, according to a new report by InterStudy, an Excelsior, Minn.-based managed care research organization.

And, newly formed HMOs aren't seeking federal qualification as often as in the past. Of the 31 HMOs that are less than a year old, 28 are non-federally qualified. By contrast, more

Continued on next page

We tailor policies to fit.



Continued from previous page
than 70% of the HMOs that are more than 10 years old are federally qualified. Federally qualified HMOs have lost market share because they have been encumbered by restrictions that have hindered their ability to compete with non-qualified rivals, experts say.

Federally qualified HMOs must offer a comprehensive health care package and cannot charge deductibles. In addition, their rating methods are sharply prescribed.

But, federal qualification has advantages.

It has been viewed as a seal of approval. In addition, under the so-called dual-choice provision of the HMO Act, an employer with at least 25 employees that does not offer its employees an HMO option must accept a federally qualified HMO if properly approached by the HMO.

The most significant change in the legislation is the provision to allow federally qualified HMOs to set advanced, fixed rates based on an individual employer's prior and projected experience. An HMO could not, however, make a retrospective adjustment at the end of the year if claims turned out higher than expected.

Currently, federally qualified HMOs tend to use a system of community rating, under which they set rates based on the costs of the entire community they serve. Under the bill, a federally qualified HMO still could use community rating.

Federally qualified HMOs also can practice community rating by class. For example, the HMO can break down the cost experience of classes of its population—such as age and gender groups—and develop separate community rates for the groups. Then, the HMO can charge the employer community rates to reflect the age and gender demographics of employees enrolled in the HMO.

Clearly, though, some federally qualified HMOs will jump at the chance to experience rate.

"Some HMOs have complained that they have priced themselves out of the market because of community rating," Mr. Doherty said.

"Employers have been crying for some recognition of individual experience," said Tim Borchert, a consultant with Hewitt Associates.

Still, other HMOs may be slow to offer experience rating.

"HMOs may lack the actuarial talent and the management information systems to calculate rates on a specific employer basis," noted Tom Billet, a managing consultant with A. Foster Higgins & Co. Inc. in New York.

The proposed modification of the equal contribution rule also would be a significant change.

Under that rule, employers have been required to make the same contribution toward the premium charged by the HMO as the largest contribution made to the largest non-HMO plan, such as a companywide, self-funded indemnity plan.

For example, if an employer contributes $200 a month for family coverage under its indemnity plan, it would have to contribute that much toward HMO coverage, as long as the HMO premium is $200 or more.

Noting that younger, healthier employees tend to select HMOs over indemnity plans, employers say that the rule forces them to pay far more for the HMO than their experience would justify.

The legislation in conference committee would require only that employer contributions to HMO plans not be financially discriminatory. For example, the legislation would allow employers to make the same percentage contribution toward HMO premiums as for other health care plans, rather than paying equal dollar amounts for both types of plans.

The legislation also would direct the Department of Health and Human Services to develop discrimination regulations.

Other provisions also will enhance federally qualified HMOs ability to compete. For example:

- Employers would be allowed to purchase from a federally qualified HMO a wide array of benefit programs—such as dental care, mental health or vision care—on a "stand-alone" basis rather than the comprehensive health care package that federally qualified HMOs now must offer.

Currently, federally qualified HMOs that want to offer fewer benefits than those required for federal qualification must do so through a separate corporation that is not federally qualified.

- HMOs would be allowed to provide up to 10% of physician services to enrollees through non-affiliated providers. As a result, an employee could receive coverage for services obtained from a physician who is not a part of the HMO's physician network.

However, HMOs could charge higher copayments and a deductible for members receiving services from non-affiliated providers.

- To be federally qualified, an HMO no longer would have to be organized as a separate "legal entity." Instead, an HMO could be a separate line of business of a larger organization, like an insurer.

"Both HMOs and employers have complained about the confusion, costliness and inefficiency" of requiring HMOs to be separate legal entities, said Sen. Edward Kennedy, D-Mass., during the Senate floor debate on the legislation.

While the legislation enjoys strong bipartisan support, some roadblocks still must be cleared before final approval is assured.

For example, the congressional conference committee will have to resolve the different approaches the House and Senate took on the right of federally qualified HMOs to force employers to offer a plan.

The House bill retains the so-called dual-choice rule, but the Senate bill includes a sunset provision that would eliminate the rule five years after passage.

"It is clear that HMOs can thrive without" the dual choice mandate, said Republican vice presidential nominee Sen. Dan Quayle of Indiana, who sponsored the sunset provision.

"I think that this industry should be allowed to evolve and compete with other health insurers free from government intrusion," Sen. Quayle said, adding that he would prefer repeal of the HMO Act.

The Senate and House bills also differ on the experience rating formula federally qualified HMOs could use for employers with 100 or fewer employees. The Senate bill would prohibit experience rates that are 10% higher than the HMO's community rate, while the House bill's ceiling is 20%.

In addition, a fight could break out in conference committee on the right of federally qualified HMOs to refuse to provide non-therapeutic abortions. ■

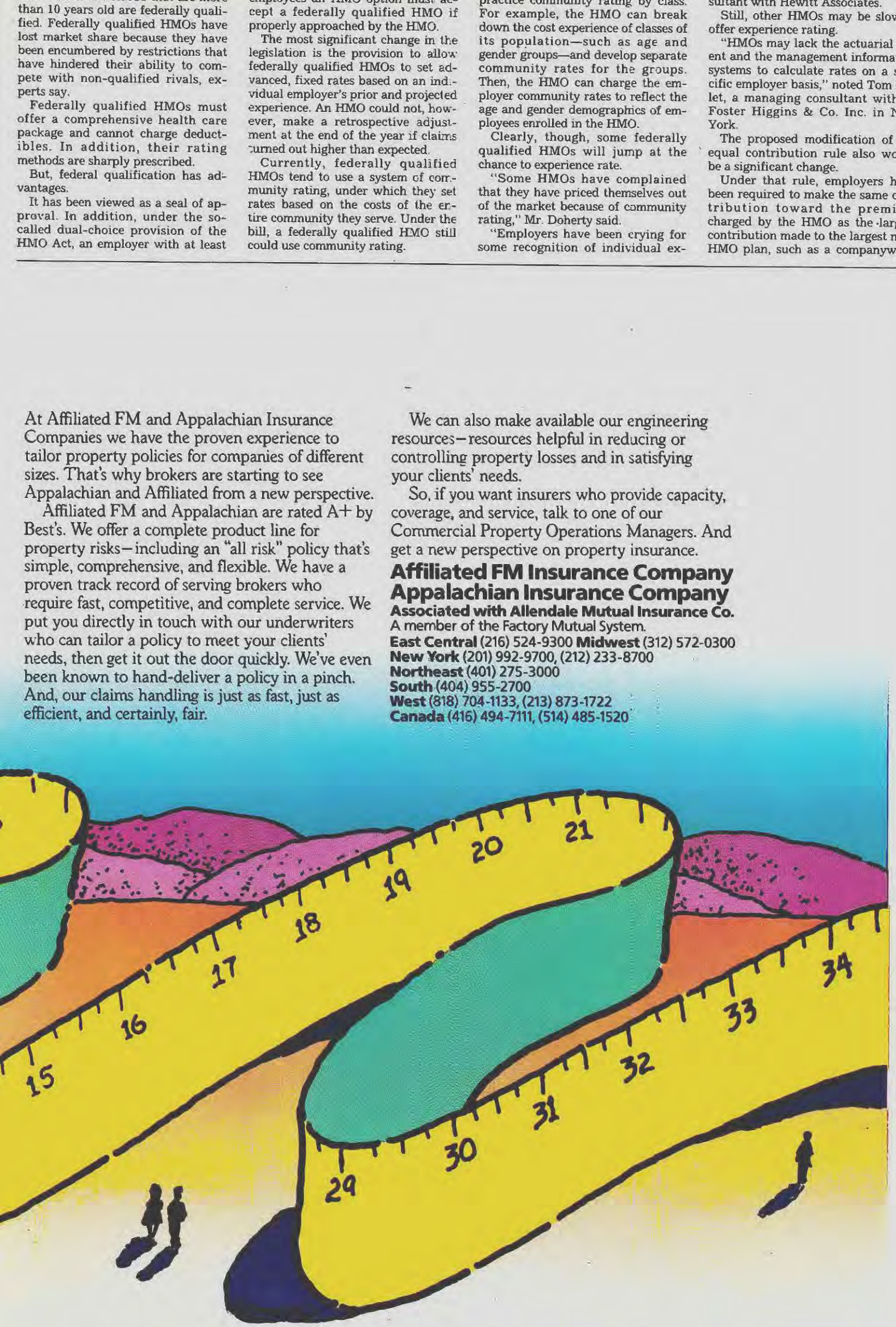
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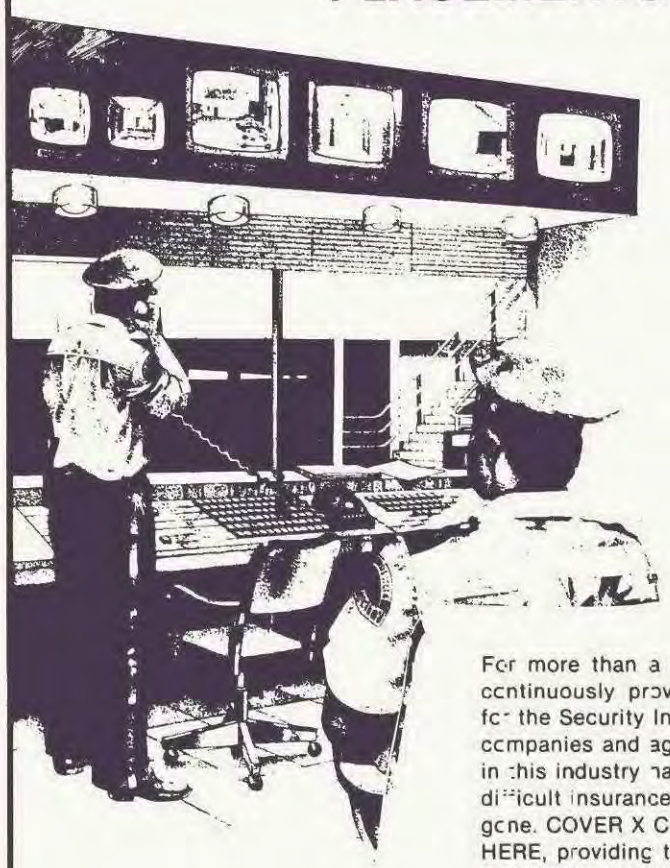
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Pollution ruling

Continued from page 2

language," said William F. Greaney, an attorney with Covington & Burling in Washington, D.C. Mr. Greaney was among several attorneys who filed amicus curiae briefs on behalf of several corporations arguing that exclusions in the policy did not bar coverage.

The brief was filed on behalf of: Berkeley Heights, N.J.-based AT&T Technologies Inc., a subsidiary of American Telephone & Telegraph Co.; Armstrong World Industries Inc. of Lancaster, Pa.; the Chemical Manufacturers Assn.; E.I. du Pont de Nemours & Co. of Wilmington, Del.; International Business Machines Corp. of Armonk, N.Y.; Olin Corp. of Stamford, Conn.; Wilton, Conn.-based Richardson-Vicks Inc., a subsidiary of Procter & Gamble Co.; and Westinghouse Electric Corp. of Pittsburgh.

The briefs in the appeal addressed the policy exclusions.

In looking at the owned-property exclusion, for example, the briefs debated whether the exclusion bars coverage for a cleanup on a policyholder's property if the hazardous waste threatens damage to third parties.

Judge Sadofski, the trial court judge, had said only: 'The exclusion clause in this policy which pertains to excluding coverage when the damage is to the policyholder's land must be held inapplicable when the danger to the environment is extreme."

In reversing the trial court, the appellate court said there is coverage for hazardous waste cleanups on a policyholder's own property if such a cleanup mitigates third-party damage.

The appellate court said Summit must prove the cleanup was necessary to mitigate imminent third-party damage for those costs to be insured.

The appellate court remanded the case to the trial court for further findings on this point.

The appellate court's decision "leaves the door open for the trial court to find that the threat of third-party property damage was sufficiently imminent for there to be coverage," said Wendy Mager, an attorney with Smith, Stratton, Wise, Heher & Brennan in Princeton, N.J. Ms. Mager filed an amicus curiae brief on behalf of the Insurance Environmental Litigation Assn., a group of 18 major property/casualty insurers. Liberty Mutual is a member of the IELA but was not a party to the amicus brief.

Ms. Mager said that some of the proof Summit will need to show that the toxic chemicals were endangering the surrounding environment was removed during the cleanup.

However, an attorney for Summit said it is clear from the state action requesting the cleanup and the complaints of workers and nearby residents that the pollution was an imminent threat to others.

In their interpretations of the pollution exclusion clause, both the trial court and the appellate court rendered rulings favorable to policyholders.

The pollution exclusion clause provides that insurance does not apply to bodily injury or property damage claims arising out of the discharge of pollution unless it is "sudden and accidental."

Both the trial court and the appellate court interpreted this to mean the pollution exclusion bars coverage only if the pollution is "expected and intended" by the policyholder.

Other courts have held that the pollution exclusion bars coverage for pollution that does not happen quickly, regardless of the policyholder's expectations.

The appellate court decision "is indicative of a trend in New Jersey courts to favor policyholders and the reasonable expectations of policyholders," said Summit attorney Dennis M. Toft, who is with Kimmelman, Wolff & Samson in Roseland, N.J.

Mitchell Lathrop, an attorney who represents insurers and is with Adams, Duque & Hazeltine in San Diego, Calif., said he felt the appellate court decision indicated a return to traditional thinking rather than trying to find insurance coverage at any cost.

The appellate court ruling is identical to the rulings of other New Jersey courts and therefore is not expected to have any great impact on similar cases nationwide, according to several attorneys.

"The decision reaffirms settled New Jersey law," said Peter J. Kalis, an attorney for Westinghouse Electric Corp., which is litigating a coverage dispute with more than 140 of its property and liability insurers in New Jersey.

An appellate court currently is reviewing a state court decision to splinter the Westinghouse case, so that only New Jersey-based claims are heard in New Jersey (*BI*, June 6; April 4; March 28).

Attorneys for Liberty Mutual were unavailable for comment. ■

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PRIMA members OK name change

WASHINGTON—Public entity risk managers voted overwhelmingly last month to change their professional organization's name to the Public Risk Management Assn. from the Public Risk & Insurance Management Assn.

The group, however, intends to retain the acronym PRIMA.

The intent of the name change is to allow the organization's name "to more accurately reflect the type of work in which its members are engaged," said Thomas Vance, president of PRIMA.

"We are in the 'business' of risk management, a field that deals with many different areas ranging from risk identification to risk financing, of which the purchase of commercial insurance is but one important aspect," he explained.

PRIMA's board introduced the proposed bylaws change at the organization's 1987 annual conference, but members asked that voting be postponed to allow for additional discussion. ■

Responsibilities

Continued from page 3

RMIS, with 82% of risk managers in this category reporting they had a computer system, compared with 81% the year before.

More risk managers also find themselves responsible for the security of computer data, not only for their own departments but also companywide.

Mr. Meyers estimated that 60% of the risk managers were responsible for data security companywide, about an 82% increase from 33% in 1983. He predicted that another 10%-15% of risk managers would assume this responsibility within the next five years.

"There are all kinds of computer systems in a company that contain proprietary data," Mr. Meyers pointed out.

"Because companies are becoming more diverse in their businesses, they create more data. There's just more volume to track," he said.

Although risk managers at large companies are less likely to be directly responsible for data security than their counterparts at small companies, the duties of risk managers at nearly all companies have expanded to include data security, the survey shows.

At companies with sales of $200 million and less, 63% of the risk managers had direct, hands-on responsibility for data security in 1987, up from 51% the year before. And 21% had supervisory responsibility, down from 35% in the previous survey.

Some 20% of the risk managers at companies with between $201 million and $500 million in sales had direct responsibility for data security, up from 14% the previous year. Some 47% more of the respondents had supervisory responsibility, up from 36%.

Some 17% of risk managers at companies with $501 million to $1 billion in sales had direct responsibility for data security, compared with 11% the year before. Some 28% of the risk managers in this category had supervisory responsibility, up from 27% a year ago.

Among the companies with $1 billion to $2 billion in sales, 8% of the risk managers had direct responsibility for data security, up from 6% in 1986. And, 37% of the risk managers reported they had a supervisory role in data security, up from 34%.

Responsibility for data security rested on the shoulders of 7% of the risk managers at companies with $2 billion to $4 billion in sales, unchanged from 1986. But more risk managers had a supervisory role in data security in 1987: 39% vs. 31% in 1986.

A total of 10% of the risk managers at companies with $4 billion to $7 billion in sales reported direct responsibility for data security, up from 8% in 1986. But 47% more reported a supervisory role, a 15-point jump from 32% in 1986.

And, while only 3% of the risk managers at companies with $7 billion or more in sales were directly responsibility for data security, no risk managers in this category in last year's survey were directly responsible for data security.

Some 27% of the risk managers in this category had supervisory responsibility for data security in this year's survey and last year's.

The survey found that more risk managers in nearly every category are responsible for safety and fire loss control engineering but that fewer risk managers are responsible for claims handling.

"The whole area of safety really dovetails with risk management," Mr. Meyers said.

Again, risk managers at the smallest companies had the most diverse duties.

Some 64% of the risk managers at companies with $200 million in sales or less reported they had direct responsibility for safety/fire loss control engineering, up from 51% a year ago. Claims handling was the direct responsibility of 73% of these risk managers, up from 67% in 1986.

Safety/fire loss control engineering was the direct responsibility of 65% of the risk managers at companies with $200 million to $500 million in sales, up from 48% in 1986. But claims handling duties was the responsibility of 58% of these risk managers, down from 68% the year before.

At companies with $500 million to $1 billion in sales, 43% of the risk managers were responsible for safety/fire loss control engineering, up from 38% the year before. The percentage of risk managers with direct responsibility for claims handling also increased, to 65% from 57%.

Among risk managers in the next category—companies with $1 billion to $2 billion in sales—36% had direct responsibility for safety/fire loss control engineering, slightly more than 35% the previous year. Claims handling was the direct responsibility of 42% of these respondents, down from 45% in 1986.

Among risk managers at companies in the $4 billion to $7 billion category, 27% were responsible for safety/fire loss control engineering, up from 25%. But the percentage with direct claims handling responsibility fell to 35% from 38%.

Some 17% of risk managers at companies with more than $7 billion in sales were responsible safety/fire loss control engineering, unchanged from last year. The percentage with direct responsibility for claims handling fell to 24% from 34%.

Only at companies with $2 billion to $4 billion in sales were fewer risk managers responsible for safety/fire loss control engineering: 24% in 1987, compared with 26% the year before. Direct responsibility for claims handling fell to 38% from 43%.

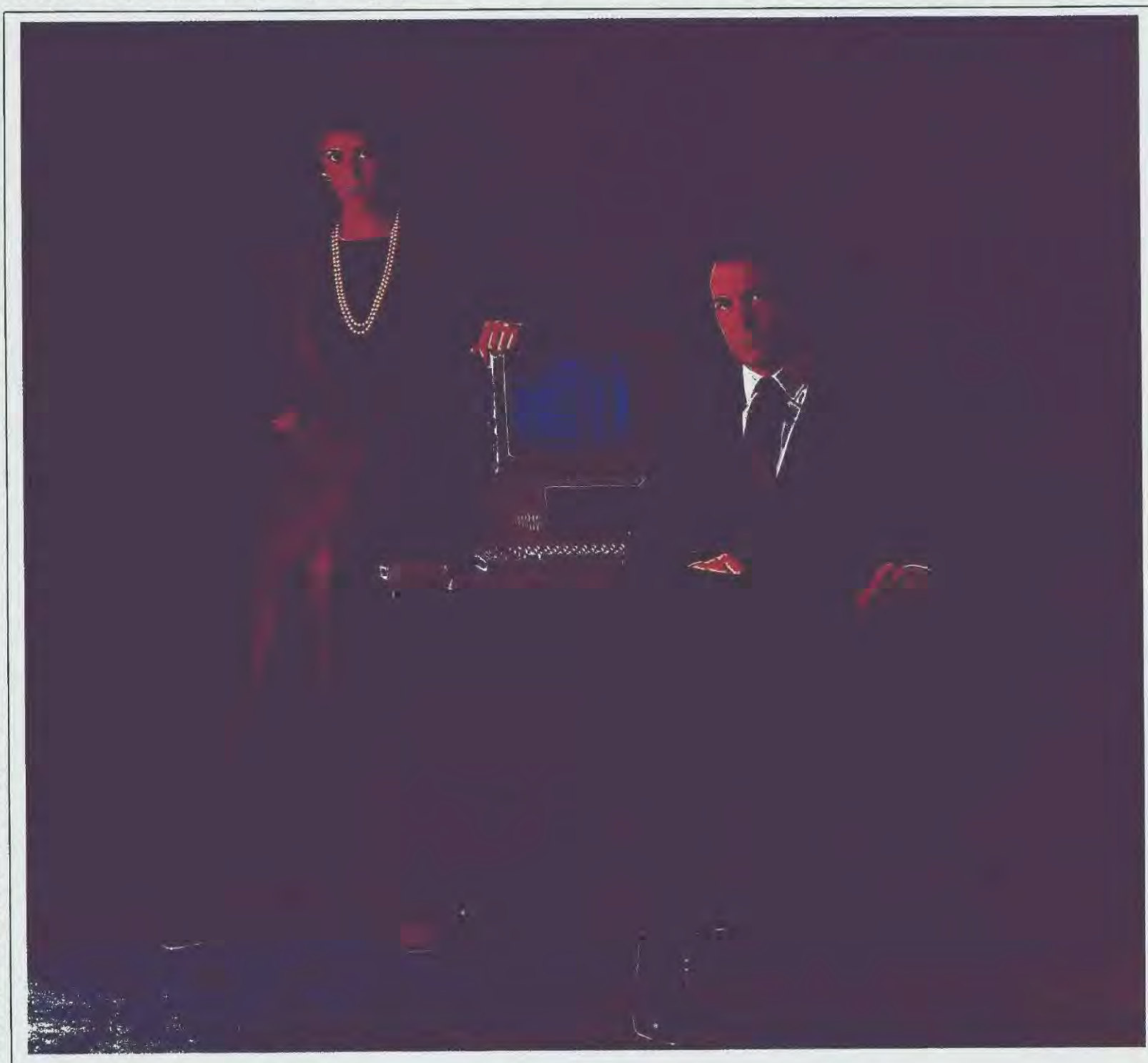
The trend of more risk managers —especially at smaller companies —becoming directly involved with employee benefits and pension/profit-sharing plan administration continues, according to the survey.

"Insurance costs are costs, so some of these companies are saying, 'Does it really matter if the costs are for property/casualty insurance or for health benefits?' " Mr. Meyers explained.

But at the largest companies, employee benefits traditionally have been viewed as a human resource function. "There are politics at all companies, but they seem to run stronger at the largest companies," Mr. Meyers said.

Indeed, at the companies with

Continued on next page



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Professional designations on the rise

Risk managers are continuing to improve their credentials by equipping themselves with professional designations, according to a recent survey of risk managers.

The Associate in Risk Management was the most prevalent professional designation held by the 1,144 risk managers surveyed by Logic Associates Inc. of New York.

The greatest percentage of risk managers with ARMs were employed by companies with $500 million to $1 billion in annual sales, both this year's and last year's survey found. Some 39% of these respondents had the credential, up from 36% in 1986.

In that same category, 17% of the risk managers were Chartered Property & Casualty Underwriters in 1987, down from 18%.

The next largest percentage of risk managers with ARMs—37%—were employed by companies with $1 billion to $2 billion in annual sales. Some 36% of respondents in this category had an ARM in 1986.

CPCU designations were held by 31% of these risk managers in 1987, up from 30%.

A total of 29% of the risk managers working for companies with $2 billion to $4 billion in annual sales had ARM designations in 1987, up from 27%. And 28% of the risk managers in that group had CPCU designations last year, up from 27% the year before.

Some 28% of the risk managers employed by companies with $4 billion to $7 billion in sales had ARM designations, up from 26%. And, 16% of the risk managers in that category held CPCU designations, up from 15%.

ARM designations were reported by 26% of the risk managers at companies with $200 million to $500 million in sales, up from 25% in 1986. Some 10% of the risk managers in that category were CPCUs, unchanged from last year.

In the smallest companies, those with $200 million or less in annual sales, 24% of respondents held ARMs in 1987, up from 23%. And 10% of the risk managers in that category were CPCUs, up from 9%.

On average, the largest companies employed the fewest risk managers with ARM designations. Some 23% of the risk managers working for companies with $7 billion or more in sales held ARM designations in 1987, up from 19%. A total of 20% of the risk managers in that category held CPCU designations, up from 19%.

The survey also gathered data on risk managers' academic credentials, which revealed that in all company sizes, the average risk manager held a bachelor's degree or higher level of education.

The risk managers at companies in three sales categories averaged 2.5—or between a bachelor's and master's degree—on a scale of 1 to 4 with 1 representing no degree, 2 a bachelor's degree, 3 a master's in business administration and 4 a law degree. Those risk managers were employed by companies with $1 billion to $2 billion in sales, $2 billion to $4 billion in sales and more than $7 billion and each category posted a slight increase from the 1986 survey.

Risk managers averaging a 2.4 educational level were employed by companies with $501 million to $1 billion in sales, also a slight increase from last year. The average education level of risk managers in the $4 billion to $7 billion category remained the same at 2.3.

And, risk managers employed at the companies in the two smallest categories—those with $200 million to $500 million and less than $200 million in sales—reported an average educational level of 2.0, unchanged from last year.

—By Karen Huelsman

Responsibilities

Continued from page 14

direct responsibility for risk financing, also down slightly from the 64% in 1986.

Of the respondents employed by companies with $1 billion to $2 billion in annual sales, 73% had direct responsibility for insurance negotiations, down from 77%. Direct risk financing duties were the domain of 68% of the risk managers, unchanged from last year.

At companies with $2 billion to $4 billion in sales, 65% of the respondents were directly responsible negotiating coverage, down from 72% the previous year. Arranging other risk financing was the direct responsibility of 62% of the risk managers, down from 66%.

Among risk managers employed by companies with $4 billion to $7 billion in annual sales, 68% were responsible for negotiating insurance policies, down from 74% in 1986. Some 75% of the risk managers in this category were directly responsible for other risk financing arrangements, down from 82% in 1986 but still the highest percentage among all categories of risk managers.

At companies with more than $7 billion in sales, 41% of the respondents had direct responsibility for negotiating insurance policies, down from 51% the year before. Some 44% of the risk managers in this category also were directly responsible arranging other risk financing, down from 46% last year and the smallest percentage among all groups of risk managers.

•

Copies of the survey are available for $60 each from Logic Associates Inc., 170 Broadway, Suite 1708, New York, N.Y. 10038; 212-227-8000.

Pension plans most common benefit: Survey

Employee benefits received by risk managers remained relatively static in 1987, according to a Logic Associates Inc. survey.

Risk managers' total compensation, however, generally increased in 1987 (*B.I.*, Aug. 15).

The New York-based recruiting firm asked risk managers about corporate pension plans, stock options, company-paid life insurance and company cars and related gas allowances in its seventh annual report on the risk management profession.

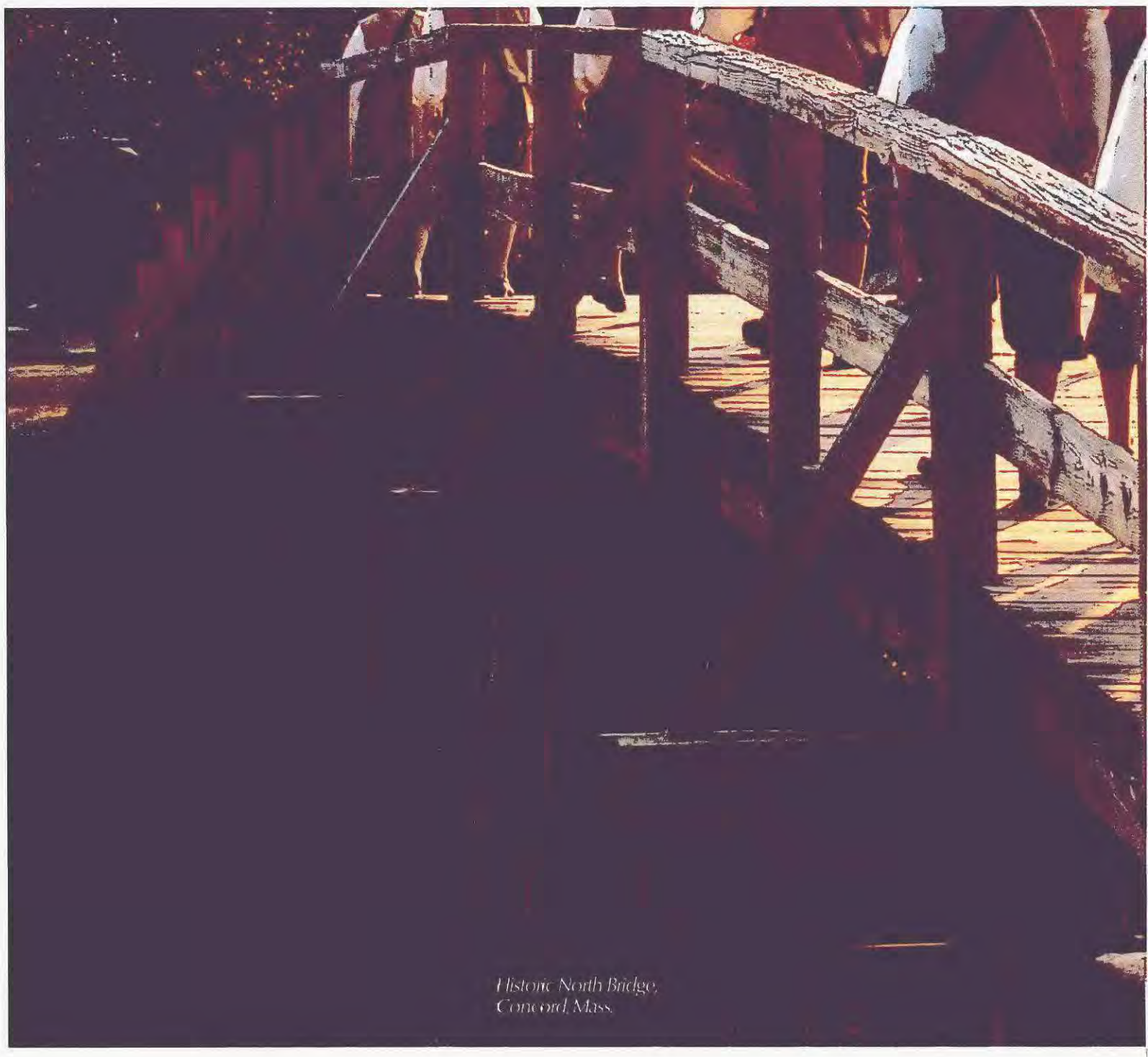
Pension plans ranked as the most common among the five benefits, with at least 90% of all respondents reporting coverage.

At companies with the highest annual sales—more than $7 billion and $4 billion to $7 billion—100% of the risk managers reported they received the benefit. This was unchanged from the 1986 survey.

Generally as the company size fell, the percentage of risk manag-

Continued on next page

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Rosina's positive, can-do outlook is typical of the 7,600 people who make up the Kemper National Property and Casualty Insurance

Continued from previous page

ers in corporate pension plans fell too, but not by much.

In the $2 billion to $4 billion sales category, also unchanged from the previous survey, 92% of the risk managers were in corporate pension plans.

In the $1 billion to $2 billion sales category, 92% of the respondents reported pension coverage, down from 93% in the previous survey.

In both the $501 million to $1 billion and $201 million to $500 million sales categories, 91% of the respondents received pension coverage.

That compares with 90% of the risk managers in the same sales categories in the last survey.

Among the smallest companies, those with less than $200 million in sales, 92% of the respondents received pension coverage, up from 91% in the previous survey.

The risk managers most likely to receive stock options worked for the largest companies, those with more than $7 billion in sales. In the 1987 survey, 74% of the respondents in this group reported stock options, up from 71% in the previous survey.

In the $4 billion to $7 billion sales category, 64% of the respondents had stock options, up from 63% the year before.

Fewer respondents in the smaller categories had stock options in 1987. In the $2 billion to $4 billion group, 55% had stock options, up from 54% the year before. In the $1 billion to $2 billion group, the figure fell to 40% in 1987 from 43% in 1986.

The risk managers most likely to receive stock options worked for companies with more than $7 billion in sales, the survey says.

The availability of stock options to respondents in the $501 million to $1 billion category remained steady at 44% in 1987. Their counterparts at companies in the $201 million to $500 million category decreased to 42% in 1987 from 43% in 1986.

In addition, 35% of the risk managers at companies with less than $200 million in annual sales had stock options, a drop from 37% in 1986.

Company cars and related gas allowance were provided to no more than 25% of the risk managers responding to the survey, and to far fewer in many sales categories.

The benefit was most prevalent in the $2 billion to $4 billion sales category, with an increase to 25% from 24% the year before.

In descending order, company cars and a gas allowance were reported by the following groups of risk managers: 23% of respondents in the $4 billion to $7 billion category, up from 22%; 21% of respondents in the $1 billion to $2 billion category, down from 22%, and with only 17% receiving a gas allowance; 19% of respondents in the $201 million to $500 million and the less than $200 million, down from 21%; 14% in the more than $7 billion category, up from 13%; and 9% in the $501 million to $1 billion category, up from 8%.

The average amount of life insurance increased or stayed the same in all the categories, ranging from a low of two times salary in the $501 million to $1 billion category to a high of 2.5 times salary in three categories: less than $200 million in sales; $201 million to $500 million; and excess of $7 billion.0 ■

3 hospitals form captive in Barbados

By KATHRYN J. McINTYRE

BRIDGETOWN, Barbados—Three university teaching hospitals are funding their first layer of excess medical malpractice insurance through a newly formed offshore captive insurance company.

Vanderbilt Medical Center in Nashville, Tenn., Washington University Medical Center in St. Louis and Baylor College of Medicine in Houston formed Southern Medical Center Insurance Co. in Bridgetown, Barbados, last month to provide the first layer of medical professional liability insurance excess of each school's self-insured retention.

The first policies were effective July 1 for all three schools.

The schools' differing self-insured retentions were set by actuarial studies and the captive's reinsurer, H.S. Weavers (Underwriting) Agencies Ltd. in London.

The schools' self-insured retentions range from $2 million per claim/$3 million aggregate to $3.5 million per claim/$10 million aggregate.

An offshore location was chosen because a U.S.-domiciled captive would be subject to taxation, explained Robert Sinclair, staff attorney and director of risk and insurance management at Vanderbilt. Mr. Sinclair also is president of the new insurance company.

Barbados was selected as the offshore domicile because premiums paid to captives domiciled there are exempt from the federal excise tax.

The captive was capitalized at $15 million, with each school contributing $1 million in cash and a $4 million guarantee.

The captive's projected annual premium volume for the year ending June 30, 1989, is about $3 million.

The captive retains $1.5 million per claim and $3 million in the aggregate under a single shared layer for the three schools.

Once those retentions are exhausted, each school has a $5 million excess layer written on quota-share basis by the captive and Weavers.

The individual schools select whether to purchase additional excess insurance from other sources, including domestic and foreign markets.

Two of the schools, Vanderbilt and Baylor, already were insured by Weavers.

Mr. Sinclair organized the first meeting to discuss a captive in November 1985. Originally, seven schools participated in the study group.

Among the other four, some that have not consolidated the insurance programs for their doctors, hospitals and medical schools have been unable to join the captive.

"You have a hard time working an aggregate excess program without consolidation," explained Mr. Sinclair. "Some are working on that."

Other medical schools may join the captive in the future, but the captive is not soliciting members, said Mr. Sinclair.

"The company will entertain inquiries," he said.

The schools deal directly with their captive without a broker's services.

The reinsurance was placed with Weavers by Johnson & Higgins and Willis Faber P.L.C.

The captive is managed by Johnson & Higgins (Barbados) Ltd.

Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc., provides actuarial services. ■

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Medicare expansion requires plan review

Q **With the recent adoption of the Medicare Catastrophic Coverage Act of 1988, is there a need any longer for employers to provide supplements to Medicare coverage?**

A To make such a determination, we should first understand the provisions of the Medicare legislation and the effective date of the various benefit improvements.

The changes will be phased in over a three-year period as follows: Medicare Part A changes will be effective in 1989; Medicare Part B changes become effective in 1990; and the new prescription drug program begins in 1991.

The most significant changes in Part A are:

✔ After an annual deductible—$564 for 1989—is met, Medicare will pay unlimited hospital costs.

Currently, only 90 days of hospitalization are covered per incidence of an illness with cost sharing for days 61 through 90. In addition, deductibles and coinsurance currently are applied to each incidence of illness.

✔ Nursing home care coverage is increased from 100 days per incidence of illness to 150 days per year.

✔ The 210-day limit on hospice coverage is unlimited when a physician certifies the patient is terminally ill.

Changes to Part B include:

✔ The out-of-pocket costs for Part B will be limited to $1,370 in 1990. All covered expenses above the $1,370 limit will be paid by Medicare.

✔ Home health care is increased to seven days a week for up to 38 days of continuous coverage, from five days a week for a two- to three-week period.

✔ Charges of up to $50 (initially) for mammography screening will be covered.

✔ Respite care for a chronically dependent individual will be provided for up to 80 hours per year, if either the Part B or drug deductible is met.

Under the new prescription drug program:

✔ Effective Jan. 1, 1991, Medicare will cover outpatient prescription drugs with a phased-in coinsurance of: 50% in 1991; 40% in 1992; and 20% in 1993.

The deductible also will be phased in at: $550 in 1990; $600 in 1991; and $652 in 1992.

It is important that companies take a new look at what they have been doing in the way of providing medical benefits for retirees eligible for Medicare and determine if the current program should continue—perhaps with minor changes—or if this is the right time to consider a new approach?

Some considerations are:

✔ Medicare coverage has been significantly expanded and improved.

✔ Medicare has established a framework for coverage and financing that can be easily expanded to include other socially desired coverages.

✔ The legislation may be the beginning of future bills dealing with long-term care, etc.

✔ This legislation goes a long way in filling gaps in Medicare coverage and protecting Medicare recipients against any financial catastrophe.

Companies are concerned over the magnitude of retiree medical obligations, and the new Medicare law offers companies an opportunity to evaluate the present and future plan design of their retiree medical plans. The following is an outline of some approaches that could be used for retirees reaching eligibility for Medicare:

✔ Revise benefit structure.

A company could provide a plan that fills the gaps in Medicare coverage, recognizing that there will be even smaller gaps in the future as Medicare continues to expand.

✔ Increase cost sharing.

An employer must consider if deductibles and copayments need to be increased or indexed, or whether contributions should be increased. Also determine if annual limits and lifetime maximums should apply to specific benefits like mental and nervous disorders.

✔ Define dollar benefit.

This approach is of considerable interest to employers as a way of limiting the escalation of

Continued on next page

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Benefit Manager, Ask A Risk Manager, Ask A Casualty Actuary and Ask A Benefit Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.



Mr. Duva

This column on employee benefits issues is written by Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Mr. Duva's and Ms. Werner's columns usually appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's next column will appear in September.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Tax reform speeds pension vesting

By The Insurance Institute of America

A.R.M. exercises

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

Because many risk management professionals increasingly are becoming involved in pension and other employee benefit financing decisions, this month's question and answer—drawn from the most recent ARM 54 national examination—explores the boundaries that both legal requirements and cash-flow demands often place on an organization's pension financing choices.

Q: The new vesting requirements that the Tax Reform Act of 1986 imposes on qualified pension plans may create special cash-flow concerns for employers, particularly with respect to funding prior service pension liabilities.

- Describe the pension vesting provisions contained in the Tax Reform Act of 1986.
- Explain how vesting requirements of qualified pension plans are likely to change the rate of return an employer can earn on the funds invested in its own operations.
- Describe the cash-flow problems likely to be associated with funding prior service pension liabilities.

When prior service benefits are large and must be funded quickly, this funding requirement may severely limit an employer's funds.

A: • To qualify for favorable income tax treatment, a pension plan must contain appropriate vesting and funding provisions. Such statutory provisions define the conditions under which an employee becomes entitled to receive his or her pension benefits.

While employers typically have chosen a vesting schedule laid down by the Employee Retirement Income Security Act of 1974 that requires an employee to be fully vested in his or her company pension plan within 10 years, the Tax Reform Act of 1986 requires even more rapid vesting schedules for plan years beginning after 1988.

Although the 10-year cliff vesting alternative will continue to be available for multiemployer plans, the new statutory vesting schedules for single-employer pension plans are: five-year cliff vesting (100% vesting upon completion of five years of service) or alternative seven-year graduated vesting (20% after three years of service and 20% for each year thereafter).

• The new accelerated pension vesting requirements are likely to lower an employer's profitability by requiring it to invest in the company pension plan funds that otherwise could have been put to more productive use in the employer's own operations.

For example, an employer may secure needed pension funds by withdrawing from or scaling down the less-profitable portions of its normal business operations.

• An employer's prior service liability under a pension plan is the employer's obligation to fund vested pension benefits attributable to the employee's service rendered before the pension plan was established. When prior service benefits are large and must be funded over a brief period—perhaps in a lump sum for employees reaching retirement—this requirement may severely limit funds available to the employer for normal business operations.

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Medicare changes merit benefit review

Continued from previous page
retiree health care costs and liabilities. A company could provide a fixed amount based on some formula that could be used either to offset the Medicare contribution or to obtain a company-sponsored plan. If the cost of the plan is more than the fixed amount provided, the retiree could pay the difference. A similar arrangement would provide a fixed dollar amount to the retiree, and the retiree could elect to purchase an individual Medicare supplement policy.

✔ Alternative delivery system.

An employer may consider introducing or extending health maintenance or preferred provider organization alternatives to retirees. HMOs, in particular, have the potential to manage the care of difficult health problems more effectively than indemnity plans.

A major consideration for this approach would be how managed care would be coordinated with Medicare. Some companies currently are meeting with government officials to determine if it would make sense financially to administer all benefits (both Medicare and the company-provided benefits) for those eligible for Medicare. The viability of such options will depend considerably on the financial arrangements that can be negotiated with the government and whether future administrations would honor these arrangements.

✔ Provide no Medicare supplement.

A company may decide that the new catastrophic Medicare program is so comprehensive and that government is planning to continue to expand Medicare to provide full coverage. Based on this conclusion, a company would not provide any supplemental coverage after Jan. 1, 1989, when Part A changes are effective, or Jan. 1, 1991, when the new prescription drug program begins.

The possible approaches above deal with those eligible for Medicare in the future. It may be possible for some companies to work out some "buy-out" arrangements for current Medicare beneficiaries by making pension adjustments, particularly if they have overfunded pension plans.

In changing plan design, a company must understand the various limitations, including requirements to provide promised benefits to existing retirees, etc., as well as the costs of complying with the sharing of savings required by the "maintenance of effort" provision in the act, as well as the tax implications of any structured "buy-out" arrangements.

It is an opportunity to discuss the cost of health care and the value of retiree benefits and the financial implications to the company, as well as to communicate future cost-containment activities.

The decision companies make with regard to what they do for existing and future Medicare beneficiaries will have significant financial implications to the corporation both now and in the future, particularly since the Financial Accounting Standards Board is moving toward a recommendation that would require a 1991 charge to earnings and a 1993 balance sheet recognition of retiree health care liabilities.

Companies must now establish business and employee relations objectives to better control and stabilize retiree medical costs. For many companies, their future financial viability could be at stake.

Bankers bond is not liability insurance

A bankers blanket bond was not "liability insurance" under Iowa law, according to the U.S. Court of Appeals for the 8th Circuit. Thus, the court said, a creditor who had obtained judgments against a bank could not recover from the bank's fidelity bond insurer.

A number of farmers in Iowa stored grain in the Prairie Grain Elevator Co. Following the suicide of Raymond Keller, part owner and manager of the elevator, the Iowa Commerce Commission closed the elevator. The commission discovered that the elevator had inadequate assets to meet the obligations of the farmers who had stored grain there.

Mr. Keller had been a member of the board of directors of the Mount Pleasant Bank & Trust Co. and the elevator was a loan customer of the bank. Some of the farmers filed a suit in state court alleging a conspiracy between the bank president and the elevator to defraud them of their grain. They were awarded damages equal to the value of the grain stored in the elevator. These judgments were ultimately upheld by the state Supreme Court.

Because the bank was subsequently placed in receivership and the Federal Deposit Insurance Corp. appointed a receiver, the farmers were unable to obtain satisfaction of their judgments from the bank. They sued again in state court against Employers Insurance of Wausau, seeking recovery on a bankers blanket bond the insurer had issued to the bank. The case was removed to the federal court where the trial court ruled for the insurer.

The appellate court here said that there is a distinction between liability insurance and fidelity bonds in that the former provides indemnity from third-party suits against the policyholder, while the latter is intended to protect the policyholder from losses resulting from its own employees' dishonesty.

Thus, the court concluded that the bankers blanket bond was not a liability insurance policy within the meaning of the law.

Anderson vs. Employers Insurance of Wausau, U.S. Court of Appeals for the 8th Circuit, Aug. 19, 1987 (*BI*/02/Feb.-$10).

Legal briefs

Work comp benefits denied

The Supreme Court of Rhode Island held that a concubine who allegedly was financially dependent upon a worker was not a "dependent" of the worker under the workers compensation law.

Rita A. Stone and Richard L. Mathieu lived together from August 1971 until his death on Nov. 15, 1977. A common-law marriage could not be created, however, because Ms. Stone was legally married to David Stone during the entire period.

Mr. Mathieu's death arose out of and in the course of his employment. At the time of his death, Mr. Mathieu had six children by a previous marriage that had been terminated by a final divorce decree on Dec. 23, 1976. Five of his children were awarded benefits. Ms. Stone also filed for dependency benefits but was denied.

On appeal, Ms. Stone claimed dependency, arguing that dependency is defined as a factual question to be determined by the circumstances, as they exist at the time of the injury. She acknowledged that she was not seeking recovery as his wife but argued that a dependent member of an employee's family should be liberally construed in light of modern changes in "family" relationships that now include cohabitation.

The court, however, said that although workers compensation statutes are generally construed liberally, they will not be so construed where to do so would defeat clear legislative intent. The court emphasized that the law here required a dependent to be "a member of the employee's family or next of kin," neither of which applied to Ms. Stone. Thus, since she bore no blood or marital relationship to Mr. Mathieu, the court said that she could not qualify as a dependent.

Stone vs. Goulet, Supreme Court of Rhode Island, March 17, 1987 (*BI*/03/Feb.-$10).

Work-site murder compensable

An employee's murder in the employer's parking lot while he was en route to his car after completing his work shift was held to be compensable under the state workers compensation law, an Indiana appellate court ruled.

At abut 11:20 p.m. on Aug. 28, 1979, Charles Ducas, an employee of Blaw-Knox Foundry & Mill Machinery Inc., sustained fatal gunshot wounds inflicted by an unknown assailant in the employee parking lot while going to his car after completing his work shift. Mr. Ducas' widow filed for workers compensation benefits. The workers compensation board ruled in her favor. The employer appealed.

The appellate court said that employees are doing something incidental to their employment in going to and leaving the workplace while they are still on the employer's premises. The fact that Mr. Ducas had just finished his work shift when he was fatally shot in the employer's parking lot, the court said, supported the board's determination that his death occurred in the course of his employment.

Blaw-Knox Foundry & Mill Machinery Inc. vs. Ducas, Court of Appeals of Indiana, March 18, 1987 (*BI*/05/May-$10).

No coverage when policy lapsed

A Tennessee appellate court ruled that an insurer had no duty to provide notice to a policyholder that the group policy had lapsed.

Mary K. Watson was the surviving spouse of the decedent, James A. Watson Jr., who died in an automobile accident on April 1, 1983. At the time of this death, Mr. Watson was an employee of Gordons Transport. Gordons provided its employees and their spouses with a group life insurance policy administered by a bank. Upon her husband's death, Mrs. Watson submitted a claim for benefits under the group policy. The claim was denied because the policy had lapsed effective Jan. 21, 1983. Mrs. Watson sued the insurer but lost in the trial court.

The appellate court said that group policy contracts are primarily between the employer and the insurance company.

It is the employer that pays the premium and there is no liability, therefore, to the insurer on the part of an individual employee. According to the court, the rights that employees acquire are merely incidental. Here the court noted that the group policy was non-contributory in that the employee contributed nothing to the payment of premium.

Thus, the court said that no contractual relationship arose between the employee and the insurer. Therefore, the court said the insurer was under no obligation to provide the decedent with notice that the group policy had lapsed.

Watson vs. Pilot Life Insurance Co., Court of Appeals of Tennessee, Aug. 27, 1987, *permission to appeal denied* by Supreme Court, Nov. 23, 1987 (*BI*/01/Aug.-$10).

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a $10 check payable to Cases Unlimited to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

InsurerTopics

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Sea of uncertainty

Ceding insurers, regulators cast for reinsurance recoverables

By DOUGLAS McLEOD

Despite efforts by insurers and regulators to come to grips with the problem, unrecoverable reinsurance still looms as a large threat to the surplus of many ceding companies, industry officials and observers agree.

Millions of dollars of outstanding balances stem not only from insolvent reinsurers that are unable to pay claims, but also from reinsurers that are financially troubled but not yet insolvent and from reinsurers that for various reasons—including disputes over contract terms—are unwilling to pay.

The National Assn. of Insurance Commissioners now is considering a proposal that would hit property/casualty insurers with penalties on reinsurance balances that are more than 90 days past due.

The proposed rule is intended to force ceding insurers to identify and deal with slow-paying reinsurers.

However, some industry sources predict that the proposal, if adopted in its current form, will not result in significant penalties for most insurers, which will take advantage of various loopholes in the rule to avoid write-offs.

Meanwhile, most large property/casualty insurers continue to grapple with the uncollectible reinsurance problem through in-house security evaluation committees and collection units.

Although some insurers say their collection efforts have been largely successful, most agree that unrecoverable reinsurance generally is still a significant problem for the industry.

Insurers typically list uncollectible reinsurance with tax reform, rate competition and a liberal U.S. tort system as the biggest threats to the financial stability of the property/casualty industry.

A national institute sponsored by the American Bar Assn. on the problem of reinsurance recoverables held in June attracted more than 300 registrants (see stories, pages 20D-20H).

Despite its high profile as a potential threat, though, very little data is available on the actual extent of uncollectible reinsurance for individual companies or for the industry as a whole (*BI*, Nov. 16, 1987).

Figures compiled by Oldwick, N.J.-based A.M. Best Co. show that total reinsurance recoverable by 1,880 property/casualty companies last year amounted to 57.3%—or roughly $59.6 billion—of total year-end 1987 policyholder surplus of $104 billion.

The figure includes reinsurance recoverable on incurred-but-not-reported losses and includes retrocessions recoverable by property/casualty reinsurers, according to a Best spokesman.

If reinsurance recoverable from affiliates is excluded, total recoverables last year amounted to 53.3%, or roughly $55.4 billion, of year-end 1987 surplus.

For 1986, reinsurance recoverables amounted to 56.4%, or about $53.5 billion, of year-end surplus of $94.9 billion, the spokesman said. If reinsurance recoverable from affiliates is excluded, total recoverables in 1986 amounted to 51.5%, or $48.9 billion, of year-end surplus.

The New York-based Insurance Services Office Inc., however, has compiled reinsurance recoverable figures for 1986 that differ markedly from Best's: According to ISO, total reinsurance recoverable by property/casualty insurers and reinsurers amounted to $80.2 billion, or 85.1% of year-end policyholder surplus of $94.3 billion.

The major reason for the discrepancy is that ISO assumed much larger incurred-but-not-reported losses than Best, according to an ISO spokesman. ISO's calculations of reinsurance recoverable for loss adjust-

Continued on next page

Recoverables

Continued from previous page

ment expenses and paid losses also were larger than Best's.

ISO has not yet compiled year-end 1987 figures, and neither Best nor ISO has attempted any estimate of how much of the reported recoverables may prove uncollectible.

Estimates of the size of the problem are hard to come by: One of the few attempts has been made by Myron M. Picoult, senior vp and senior insurance analyst with Oppenheimer & Co. in New York.

Mr. Picoult projects that roughly $10 billion, or 16.6% of total 1987 recoverables of $59.6 billion, may prove to be bad debts (*BI*, Aug. 1; July 25).

The exposures of various companies to unrecoverable balances differ, as total reinsurance recoverables as a percentage of surplus varies widely from insurer to insurer.

On average, 27 insurers surveyed by Mr. Picoult reported total reinsurance recoverables amounting to 110.9% of surplus in 1987. If funds withheld securing reinsurance with unauthorized reinsurers are subtracted, adjusted recoverables amounted to an average of 90.6% of surplus for the 27 insurers.

Among the largest insurers in this group, total recoverables as a percentage of surplus ranged from highs of 331.5% for Kemper Corp. and 309.7% for Crum & Forster Inc. to lows of 21.8% for SAFECO Corp. and 44.5% for General Re Corp.

The reactions of insurers to the problem also have varied, with some companies taking a more aggressive stance in pursuing recoveries and establishing bad debt reserves.

In general, though, Mr. Picoult said the industrywide problems with unrecoverable reinsurance

The problem has 'not been addressed as effectively as it could or should be,' says Myron Picoult.

have not improved much in recent months.

"It has not been addressed as effectively as it could or should be," he said. "Over the next two years, there is going to be an incredible amount of pressure to get these things into shape.

"Everybody is waiting to see what the NAIC is going to do," he added.

The NAIC's proposal on aging reinsurance balances is scheduled for discussion at the group's Blanks Committee meeting in October and would apply to property/casualty insurers' 1989 financial statements, which will be filed in 1990 (*BI*, July 18).

Under the proposal, ceding insurers would be forced to take a charge against surplus equal to 20% of reinsurance recoverable from an individual reinsurer if the reinsurer is more than 90 days late in paying claims.

The 90-day period starts when the reinsurance contract says payment is due, according to the proposal. If the contract is silent regarding payment terms, payment is assumed to be due 30 days after the reinsurer is billed by the ceding company.

The balance to which the 20% penalty applies varies depending on the reinsurer's payment history.

If the reinsurer is late with less than 10% of total paid losses it owes to the ceding company, the ceding company is penalized 20% of the past due balance on paid losses only.

However, if the reinsurer is late with more than 10% of total paid losses, the 20% penalty applies to both paid and unpaid losses recoverable.

Sources familiar with the proposal say that 20% figure—which was a compromise—is still open to discussion, and that some regulators have argued that 100% of past due balances should be written off.

Industry officials also disagree about the likely impact of the proposal, if it is adopted by the NAIC.

Edmond F. Rondepierre, senior vp and general counsel of General Reinsurance Corp. in Stamford, Conn., expressed doubts about whether a significant number of ceding insurers will actually suffer penalties under the proposal despite reinsurance collection problems.

"There are just too many ways for people to avoid ever having to take a penalty," Mr. Rondepierre observed.

For example, he noted that the proposal provides an exception from the penalty in cases where there is a "legitimate dispute" between the ceding insurer and reinsurer over whether certain losses are covered.

Under the proposal, ceding insurers would have to include a separate note in their statutory statements detailing:

- A disputed balance from an individual reinsurer that exceeds 5% of the ceding insurer's surplus.
- All disputed balances from all reinsurers if the total in dispute exceeds 10% of the ceding insurer's surplus.

It would not be difficult for a ceding company wishing to avoid a penalty to demand arbitration against a reinsurer and claim that an overdue balance is in dispute, Mr. Rondepierre suggested.

In addition, he noted that an early version of the proposal stated that reinsurance payments are due when the reinsurance contract says they are due. Under this provision, he noted, there was nothing to stop a ceding company wishing to avoid a penalty from amending the contract to extend the payment period.

The proposal was later changed to prevent any such extension of payment terms for purposes of statutory accounting.

Nevertheless, it will be difficult, if not impossible, for insurance departments to keep track of the terms of individual contracts, meaning that the ceding insurers will be left to determine which claims fall into the past due category, Mr. Rondepierre said.

Some ceding insurers may not include balances that should be categorized as past due, he pointed out.

However, members of the NAIC's Study Group on Property and Casualty Reinsurance, which formulated the proposal, say they don't expect any widespread attempts to circumvent the proposal's requirements.

Most ceding insurers will not be inclined to grant slow-paying reinsurers additional leeway on past due balances, they say.

"You are giving the use of your money away," said one study group member. "It doesn't seem to me that many people would want to give away the use of their money."

"I don't think a lot of people would jump on that option to say, 'Hold my money for me,' " another group member concurred. "Are they committing suicide, or what?"

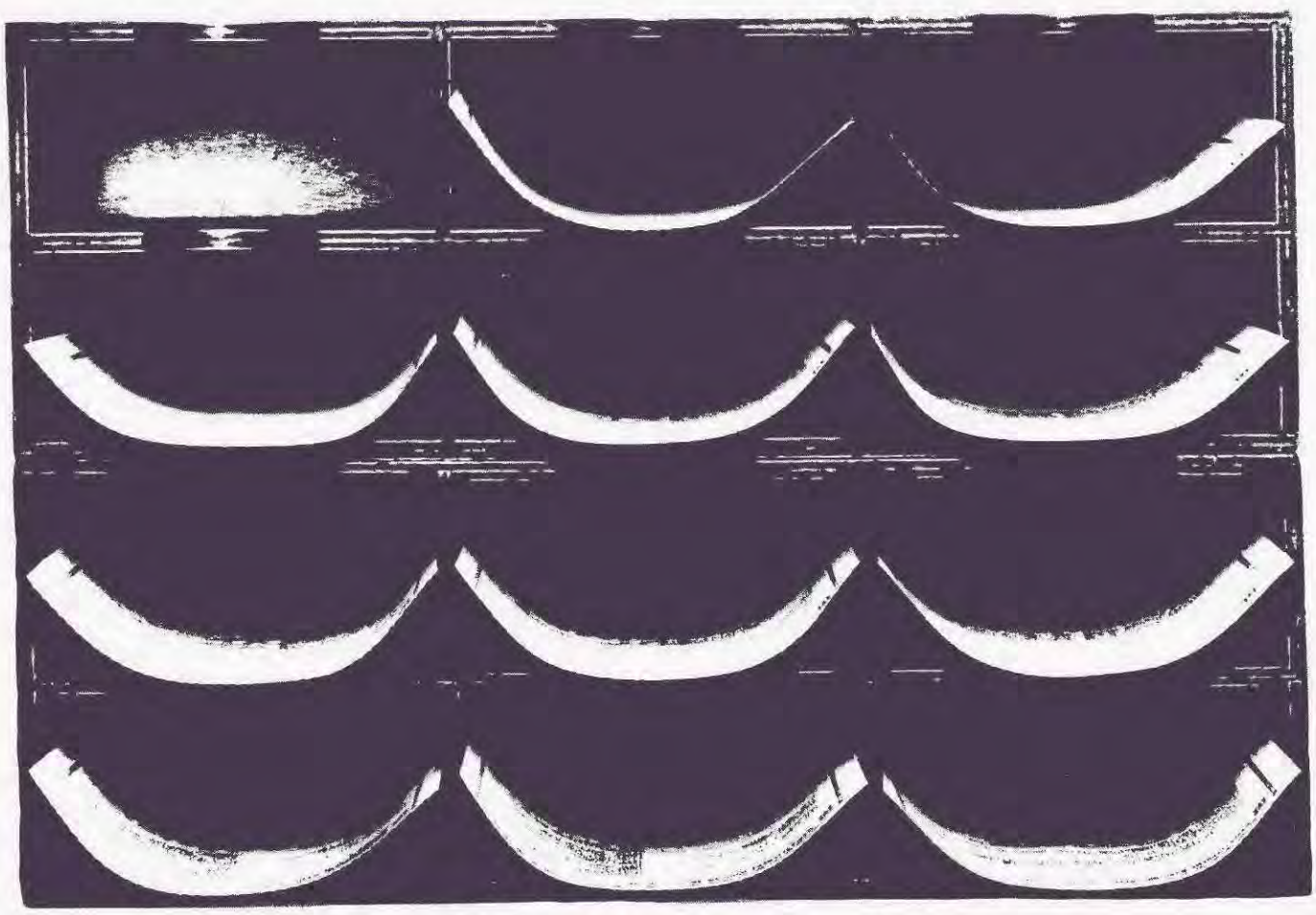
"People can avoid (the penalties), but it doesn't make good sense from a business perspective," the study group member said.

Despite potential shortcomings in the proposal, Mr. Rondepierre agreed that the NAIC proposal is a step in the right direction toward dealing with the increasing prob-

Continued on page 20D

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Recoverables

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lem of slow-paying reinsurers.

"At the very least, it has focused people's attention on the problem," he observed.

Meanwhile, ceding insurers are following procedures and systems established in recent years to deal with uncollectibility, including security evaluation committees to review the financial stability of new and existing reinsurers, and collection units whose only job is to pursue past due reinsurance balances.

Crum & Forster, for example, has established a task force to deal with past due reinsurance balances, with members drawn from the reinsurance placement, financial, legal and other areas of the company, according to Senior Vp Thomas Warnke. Crum & Forster also has a separate reinsurance security committee to examine prospective reinsurers, he noted.

Mr. Warnke said the company has not yet arrived at any estimate of its unrecoverable reinsurance balances.

"We are still in the process of analyzing the best way to determine what the recoverables are," he explained.

"It's a matter of estimating and having a rationale for the estimate," he added. "We have never really had to do this before and we are still learning how to do it."

Aetna Casualty & Surety Co. set up a separate reinsurance collection unit in early 1986. Among other things, the unit set up a centralized computer system to keep track of bills sent to reinsurers, when payments are received and whether the payments are partial or complete, according to Pedro Santos, manager of reinsurance administration.

"We have a clear and good audit trail on outstanding balances," Mr. Santos noted.

The unit also has stepped up collection efforts, meeting more frequently with intermediaries and direct reinsurers and discussing billing questions face to face with delinquent reinsurers, he said.

Improved accounting systems also have allowed Aetna to include the payment history of its reinsurers in the files used by its reinsurance security committee in reviewing the acceptability of reinsurers, Mr. Santos noted.

American International Group Inc.—which observers say is successful in dealing with past due balances despite its heavy use of reinsurance—has had a security committee for more than a decade and a collection unit coordinating the efforts of various operations for more than four years, according to Vp Christian Milton.

AIG has secured the obligations of many of its reinsurers in various ways, including with cash, letters of credit or escrow accounts, he said, adding that AIG's security committee also has been tough in its reviews of reinsurers.

AIG also has added conditions to reinsurance contracts allowing it the option of commuting losses with reinsurers that fail the NAIC's Insurance Regulatory Information System ratio tests related to capital and surplus, Mr. Milton said. Previously, AIG's reinsurance contracts called for commutation only when the reinsurer's capital and surplus actually became impaired.

Mr. Milton added that many large property/casualty insurers now have a good idea about the extent of their unrecoverable problem, and that the biggest threat is to smaller insurers that have bought more reinsurance in lower layers and have delayed analysis of the unrecoverability problem for fear of the results.

"The smaller the company, the more vulnerable it becomes," he said. ■

Some collections need special tactics

By KATHRYN J. McINTYRE

NEW YORK—Reinsurance collections become a problem needing more than the typical approach by ceding companies when the reinsurer is insolvent, financially troubled or "recalcitrant," according to a ceding company executive.

"This is particularly so in the event that the amount of loss dollars potentially recoverable from such reinsurers is substantial relative to the cedant's surplus or earnings," said David R. Robb, assistant vp of Hartford Insurance Group in Hartford, Conn.

To ignore the need for a more substantial collection effort will cost the ceding company money, he suggested.

Mr. Robb submitted a paper, "The Structure of a Reinsurance Collections Program" for a National Institute on International Reinsurance Collections and Insolvency sponsored by the Tort & Insurance Practice Section of the American Bar Assn. in June in New York.

In his paper and his remarks to the group of more than 300 lawyers and others concerned with reinsurance collections, Mr. Robb described when a reinsurance collection program is needed and how to make it successful.

"There is no need to create an elaborate sophisticated collections program if a company has not found standard practice to be inadequate," Mr. Robb wrote in his paper, commenting that the intermediary system of collecting reinsurance claims works "quite adequately for much of the reinsurance loss recoveries in the course of collection."

However, he continued, "the issue becomes a bit more murky when an insurer faces recoveries from insolvent, financially troubled or recalcitrant reinsurers.

"In these cases, even the highest level of cooperation from the very best professional intermediaries may not prove to be adequate. The cedant will need to develop some kind of collection program or face the unpleasant likelihood of having to write off a larger portion of its reinsurance losses recoverable from such reinsurers than will a primary carrier with an effective collection program."

Mr. Robb suggested that a successful reinsurance collection program managed by a ceding company adhere to at least some of the following organization concepts:

- Centralization of the program in the home office.

"This unit should have the ability to control ceded premiums in order to facilitate the handling of net settled accounts, file notices of loss, process ceded losses, apply cash, age receivables, develop management information and publish financial impact and analysis reports," he wrote.

Continued on next page

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- A single contact should be established for reinsurers and intermediaries to discuss reinsurance issues, "particularly for disputes and difficult cases," Mr. Robb said at the meeting.

"Whenever possible, the centralized reinsurance collection department should be designated to receive all inquiries and should send out all bills, notices, proofs, reports and coordinate answers to reinsurers' questions," he wrote in his paper.

- Routine processing should not get "bogged down" by difficult collection or billing issues.
- A special collections unit should work with reinsurers and intermediaries on collections that fall outside of the routine.

The unit should coordinate the ceding company's "external collection efforts, including exercising offsets, drawing down letters of credit or trusts and initiating litigation or arbitration to enforce collection."

- Authority to settle for less than 100% of the ceded claim amount should be clear.
- A close working relationship should exist between the reinsurance collection function and the reinsurance buying department to maximize collections and avoid doing business with reinsurers that don't pay on time or in full.
- A "workout unit" should be created to work with financially troubled reinsurers or companies in liquidation or rehabilitation. The team should include "specialists with an extensive knowledge of the insurance and reinsurance business."

Key support needed by a reinsurance collection program includes:

- Lawyers, who, when disputes arise, can determine the ceding company's legal position and whether to initiate legal proceedings.

Know the difference between a company that can't pay and a company that won't pay,' Mr. Robb says.

"In this context, a lawyer's role as counsel rather than that of advocate is particularly helpful to business people who, in good faith, are trying to maximize collections in the most effective way," Mr. Robb wrote in his paper.

- Claims people, whose "assistance and cooperation" is vital. Claims people are responsible for "the early notices of loss, accurate and comprehensive reports to reinsurers and timely response to requests for information and documents."

While the central collection department is designed as the contact point for inquiries, "the ability of a company to ultimately fulfill this part of the collection process resides almost exclusively in the hands of its claims personnel," Mr. Robb wrote.

- The reinsurance buying department, which can comment on the "intent of the parties" and the negotiation process that lead to the final wordings.
- Data processing, which is needed to help maintain accurate records and generate accurate and timely reports.

"A reinsurance billing and collection system which generates confidence on the part of reinsurers that accurate information is being presented will reduce demands for audits and accelerate the collection of cash," Mr. Robb wrote.

He also warned, "Data processing systems designed for simpler reinsurance arrangements may well prove to be inadequate when called upon to process information in today's more complex environment."

The reinsurance collection unit, when confronted with a problem collecting, has to "determine the difference between a company that can't pay and a company that won't pay," Mr. Robb advised in remarks.

If the company can't pay, Mr. Robb advised finding "alternatives to liquidation" of the reinsurer.

Alternatives to forcing a reinsurance company into liquidation include an agreement by the ceding company to accept payment on terms other than immediate cash payment.

The ceding company, for example, could accept a combination of cash and some form of surplus note or debenture; could accept equity in the reinsurer; could extend time payments on a scheduled basis; or could accept direct access to a reinsurer's retrocessionaires, according to Mr. Robb.

When dealing with a reinsurer that has the money to pay but won't pay reinsurance claims, Mr. Robb suggested alternatives to legal proceedings, including: drawing down on letters of credit; offsetting premiums due to recover unpaid losses; and leveraging an ongoing business relationship.

However, when all else fails, legal proceedings may be the solution.

As a gangster once said, "You can get more money with a kind word and a gun than with a kind word alone," Mr. Robb quipped. ■

300 attend reinsurance institute

NEW YORK—More than 300 lawyers and others interested in reinsurance collections and reinsurer insolvencies attended the American Bar Assn. National Institute on International Reinsurance Collections and Insolvency.

The institute, sponsored by the Tort & Insurance Practice Section of the ABA and four of its committees, was organized "because so many reinsureds are having such a large amount of trouble collecting their reinsurance," said National Institute Co-Chair David M. Spector. "It's a problem that has become endemic in the industry," said Mr. Spector, who is a partner with Mayer, Brown & Platt in Chicago.

In addition to lawyers in private practice and with insurance and reinsurance companies, other registrants included staffers from state insurance departments and employees of the Internal Revenue Service and the Federal Trade Commission.

John Milligan-Whyte, a consultant with O.A. Smith's Attorneys in Bermuda, was the other co-chair for the institute.

The 20 papers submitted for the institute have been published under the title: "Law and Practice of International Reinsurance Collections and Insolvency." Each book costs $89.95 ($79.95 for TIPS members) and can be ordered by writing American Bar Assn., Order Fulfillment 519, 750 N. Lake Shore Drive, Chicago, Ill. 60611.



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Commutations gain importance: Actuary

NEW YORK—Commutation of reinsurance treaties, previously used to eliminate relatively small transactions, is now a vital element of salvage plans for financially troubled companies, says an actuary.

As a result, reinsurance commutations "should be evaluated as a business proposition" advises David S. Powell, a consultant with the Tillinghast Division of Towers, Perrin, Forster & Crosby Inc.

"If you get a letter demanding commutation, get a lawyer," because the commutation "should be viewed just like the settlement of any controversy," advises Eugene Wollan, a partner with Mound, Cotton & Wollan in New York.

Commutation of a reinsurance agreement is the immediate settlement of all obligations between the parties, including those currently due as well as those projected for the future.

Mr. Powell and Mr. Wollan discussed reinsurance commutation during the American Bar Assn. National Institute on International Reinsurance Collections and Insolvency in June in New York.

"There are no fixed rules to the game," observed Mr. Powell. "The side best prepared usually comes out ahead."

Being prepared means understanding the value of the deal and the financial position of both parties, he explained.

The elements determining the value of the deal include:

- The value of unpaid losses, which includes case reserves and reserves for incurred-but-not-reported losses. This is determined by a detailed actuarial analysis.
- The value of disputed items.
- The value of present balances due.
- The value of return premiums and future premium due.
- The value of the risk that the projections will turn out wrong.
- The value of the risk that the reinsurer could go broke.

The last, Mr. Powell noted, is "frequently a main motivation for commutation—get some money now rather than take chances later."

Generally, an assuming company will want to consider a commutation when it has the cash and wants to get rid of liabilities, as well as when it wants to settle legitimate disputes. For the ceding company, it is often a case of a reinsurer seeking a commutation with the warning that if the contract isn't commuted, the reinsurer will go into liquidation. The ceding company in this situation has to determine if that is true or if it is a negotiating ploy, Mr. Powell advised. If it is a solvent reinsurer and there are no legitimate disputes, but claims aren't being paid, "I don't like seeing a ceding company bullied into a bad deal," Mr. Powell said.

There are alternatives to a full commutation, Mr. Wollan noted. The ceding company and reinsurer can compromise with an agreement for the reinsurer to keep paying claims, but at less than 100% of the liabilities. Or a cap on the liabilities can be negotiated.

Mr. Wollan pointed out that since there often is an "us-vs.-them" undercurrent in relationships between ceding companies and their reinsurers, "it behooves a lawyer advising a client on a commutation to view it as any settlement."

However, in settlements, lawyers often take the position that "if the other side wants it, I don't," Mr. Wollan said. "Loss commutations can't be dealt with that simplistically."

In negotiating reinsurance commutations, one may want to ignore the conventional wisdom that appearing willing to negotiate is a sign that the case is weak.

"A really good commutation," said Mr. Wollan, is one in which "each side is a little bit unhappy, but not so much they wouldn't do it."

—By Kathryn J. McIntyre

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Ceding insurers must collect quickly: Expert

NEW YORK—Ceding companies create many of their reinsurance collection problems because they fail to act quickly, contends a reinsurance expert.

"The key is to take action. Be aggressive. The more quickly you attack a problem, the more likely you are to find a solution," advises Ivor Kiverstein, managing director of Chiltington Intermediaries Ltd. in London. The firm helps clients collect reinsurance payments and negotiate reinsurance contract commutations.

In being aggressive, a ceding company should "be on top of the broker," making the broker fulfill its responsibilities, Mr. Kiverstein said. Reinsurance brokers are "paid to collect claims," he pointed out during remarks at an institute in June sponsored by the American Bar Assn.

In dealing with the reinsurance broker, the ceding company should be forceful in obtaining information on the status of reinsurance claim payments and details on which reinsurers owe money and how much, he said.

"Pester the broker to get him to do his job," Mr. Kiverstein said.

When a reinsurer isn't paying a claim, the ceding company should find out the reason from the broker. "You may be able to nip it in the bud," he said.

But while encouraging ceding companies to make their brokers work, Mr. Kiverstein said, "I don't agree it is not economical to contact the reinsurer."

While it would not be economical to fly to, say, South Korea, to discuss a claim, the ceding company can inquire about a claim payment via the telephone, telex or fax.

"Maybe your problem simply got lost," he said of reinsurance claims that have not been paid.

But when real problems with collecting a reinsurance claim exist, they are usually related to financial problems for the reinsurer, political or economic problems where the reinsurer is located, disputes over liability, or the reinsurer has been placed in liquidation or rehabilitation.

The solutions, Mr. Kiverstein said, are offsetting premiums due by amounts owed on claims, commutation of the contract or a joint audit, which can be used to resolve a dispute.

Ceding companies should not "give up when a company goes into liquidation," Mr. Kiverstein stressed. "Outside the United States, all creditors are treated equally," he pointed out.

Finally, Mr. Kiverstein said, "litigation is the last resort."

—By Kathryn J. McIntyre

Reinsurance payment delays discussed

NEW YORK—Reinsurers say they have good reasons for delaying or refusing to pay claims, while ceding companies contend reinsurers are unfairly dragging their feet.

Determining whether a reinsurance claim today is "legitimate" is "an extremely complicated matter," according to John S. Butler, legal officer of The Mercantile & General Reinsurance Co. P.L.C. in London.

Because U.S. courts have found coverage under insurance policies that was never intended when the policy was written, "lots of reinsurance claims have been paid that shouldn't have been paid," according to Mr. Butler.

However, Thomas Warnke, senior vp of Crum & Forster Inc. in Morristown, N.J., observes: "Ceding companies have to pay till they drop. There is no reason reinsurers shouldn't be in the same position."

Both executives spoke at an American Bar Assn. National Institute on International Reinsurance Collections and Insolvency held in June in New York.

Reinsurance contracts are "complicated documents," Mr. Butler observed. "A lot of reinsurers and insurers didn't understand the contracts they were entering into," although "they thought they did."

"Reinsurers now are looking at the contents" of reinsurance contracts, Mr. Butler said.

The problem of interpreting the contracts is especially acute with excess-of-loss reinsurance contracts, Mr. Butler said.

'A lot of reinsurers and insurers didn't understand contracts they were entering into,' says Mr. Butler.

In addition, Mr. Butler observed, the practice of spreading reinsurance contracts around the world, with each reinsurer taking as little as 1% or 2% of a contract, further complicates reinsurance claim settlements.

When only a few reinsurers are involved, a claim can be resolved quite quickly, he explained. But, "if there are 200 on the program, you are going to have delays," he said.

Furthermore, because some claims, like asbestos, involve contracts going back 20 to 40 years, the records may not be available, he said. "Reinsurers, particularly at Lloyd's (of London), aren't great for keeping records," Mr. Butler said.

Mr. Warnke, however, suggested that "reinsurers are in a good position to delay" paying reinsurance claims because they hold the money and the leverage.

Instead of denying the claim, or reserving their rights not to pay the claim, reinsurers can delay paying claims simply by asking "interminable questions," Mr. Warnke said.

He blamed reinsurance collection problems on a "lack of mutuality" between the ceding company and the reinsurer.

"The reinsurer wants you to disclose everything" when negotiating to purchase reinsurance, but when negotiating "commutations, they don't want to disclose how much they expect to save," he said.

And, "reinsurance companies can inspect ceding companies but ceding companies can't inspect reinsurers or see audit reports," he added.

Mr. Warnke advised ceding companies to improve their own records to document transactions and to require their reinsurance intermediaries to improve their record-keeping, as well.

When faced with a dispute over a reinsurance contract, a ceding company should realize that litigation is expensive and time-consuming, he said. However, arbitration proceedings have "almost reached the level of litigation in time and complication," he observed.

Mr. Butler noted that arbitrations in England are shorter, because there is not as much discovery or depositions.

"In England, I prefer the courts. The main argument against arbitrations is that there are no precedents. You can find yourself arbitrating the same thing over and over."

Short of litigation or arbitration, ceding companies have some leverage when dealing with reinsurers, Mr. Warnke suggested.

Ceding companies have the right to offset from premiums owed to reinsurers the amounts the reinsurers owe them, he noted.

And, ceding companies can liquidate collateral they hold, although "banks can balk" at ceding companies drawing down on a letter of credit, he noted.

Ceding companies seeking payment of reinsurance claims also can leverage their future business relationship.

But, most important, Mr. Warnke said, is for ceding companies to "rebuild and re-establish good faith partnership relationships" with reinsurers.

Predicting more adversarial proceedings in the next three to five years, Mr. Warnke said: "Those left will establish more legalistic relationships, more precise contracts and better understanding of the exposures involved."

—By Kathryn J. McIntyre

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Reinsurance arbitrations still thrive

By KATHRYN J. McINTYRE

NEW YORK—Arbitration of disputes is a popular alternative to litigation in the reinsurance business, where disputes have become more frequent, reports an attorney specializing in reinsurance.

"And arbitration serves the industry well," says Jonathan Bank, a partner with Buchalter, Nemer, Fields & Younger in Los Angeles.

"Reinsurance is a business relationship and, therefore, disagreements can arise," Mr. Bank said. However, disputes in the reinsurance business formerly were "the exception," Mr. Bank noted, because reinsurance transactions were built on "good faith" and long-term relationships.

Since the 1970s, with an influx of new reinsurers and intensified competitive pressures, "disputes are more frequent," he said.

Arbitration of disputes has thrived in the reinsurance business because most treaties contain clauses calling for arbitration instead of litigation, as do many facultative agreements, Mr. Bank explained in remarks at the American Bar Assn.-sponsored National Institute on International Reinsurance Collections and Insolvency held in June in New York.

Arbitration clauses date back to at least the 1890s when they were commonly found in English marine reinsurance agreements because English law made enforcement of agreements difficult, Mr. Bank explained in his paper. The practice gradually was adapted to other classes of reinsurance and eventually became customary in the United States.

Since the enactment in 1947 of the Federal Arbitration Act, the courts have had the power to enforce arbitration agreements by compelling arbitration, staying litigation pending arbitration and confirming arbitration awards.

Mr. Bank described the arbitration process and provided some hints for participants.

Generally, it is difficult for parties to a reinsurance agreement with an arbitration clause to avoid arbitration, unless one party can show that there was fraud in the inducement of the arbitration clause itself. And that is a "stiff burden," Mr. Bank said.

However, the availability of arbitration when one of the parties is in liquidation is unclear, he said.

"The right to arbitrate may be nullified by the intervention of insolvency proceedings," he explained. "Thus a reinsurer may be unable to enforce an arbitration clause against its ceding company's liquidator based on an overriding public policy vesting the liquidation court with exclusive jurisdiction over all matters affecting the insolvent company."

In a recent case involving the insolvent Ideal Mutual Insurance Co., the U.S. District Court for the Southern District of New York found that the McCarran-Ferguson Act pre-empted the Federal Arbitration Act and thus the liquidator could not be forced to arbitrate.

However, in an earlier case in 1985, the liquidator of two insolvent insurance companies was compelled to arbitrate a dispute with a solvent reinsurer.

Mr. Bank predicted more litigation on this issue.

In an arbitration, a three-person panel of retired insurance or reinsurance company executives is appointed to resolve a dispute. Mr. Bank explained that active executives may be too busy to take part or may not want to get involved in disputes.

Each party selects an arbitrator and the arbitrators agree on an umpire. Mr. Bank warned that when the arbitrators can't agree on an umpire and the umpire has to be selected by lots from names submitted by both sides, each side must submit the names of neutral people to serve as umpire "or else it becomes a crap shoot" as to whether the panel will be unbiased.

Mr. Bank also advised that at least one of the arbitrators be experienced in arbitrations so the panel is not intimidated by the lawyers representing the parties in the arbitration.

Once the panel is in place, the parties present their positions, through briefs and hearings. The arbitrators, Mr. Bank noted, do not have to follow the strict laws of evidence.

The parties can agree to limited discovery, Mr. Bank said.

In determining whether to use expert witnesses at an arbitration hearing, Mr. Bank advised: "If you have three experts before you, you have more expertise than you could get. You could offend the panel," by bringing in other experts.

Arbitrations can last six months to a year, but it's not unreasonable for an arbitration to go on for years, Mr. Bank said.

An arbitration panel can award compensatory damages, rescind contracts or reform contract language and require specific performance of the contract. In addition, if the arbitration clause does not bar punitive damages, the panel can award them.

The panel also may apportion the costs of the arbitration proceedings.

If the losing party fails to abide by the panel's award, the winning party seeks confirmation of the award from the district court with jurisdiction over the dispute, giving the award the effect of a civil judgment, Mr. Bank explained.

Once a judgment is entered, legal proceedings may be used to enforce a judgment.

"There are numerous potential advantages to arbitration over litigation," pointed out Mr. Bank.

Arbitration is less technical, and therefore less expensive, he said. "The informal procedure saves both time and money."

And, by saving time and money, arbitration minimizes the possibility that one party can win merely by having superior resources to outlast its opponent in expensive litigation, he pointed out.

Also, arbitration decisions are usually based on business experience and custom, rather than on technical legal principles.

And, arbitration proceedings are confidential.

However, the very nature of arbitration can create disadvantages to those with a technical legal defense or when fraud is alleged and discovery is important.

And, arbitration does not provide any precedents.

Also, any third party involved in the dispute but not party to the arbitration agreement cannot be compelled to join in the arbitration process. ■



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Hurricane exposure

Continued from page 1

uation is different," he explained.

But businesses in hurricane zones do suffer common exposures and can follow common strategies to a point, Mr. Gebeau said.

Proper maintenance of facilities is a key factor in minimizing hurricane damage, Mr. Gebeau said. Loose siding rips off easier than its securely fastened counterparts and poorly anchored storm drains can be rendered useless when they are most needed, he said.

One facet of maintenance that might be overlooked is that of yard stock—skids, building materials, demonstration units and signs. "We like to see a pre-planned procedure for moving that stuff inside," Mr. Gebeau said. Otherwise, loose materials "can become missiles" when the wind begins to howl, he said.

Mr. Hanneman agrees that while circumstances differ from company to company, the most important thing to do before a hurricane strikes is to "make sure everything is put away. Button up."

At Ryder System Inc.'s headquarters in Miami, "We button up all of our buildings. Anything that can blow is locked away," including ashtrays on desks near windows," said W. Michael McDonald, Ryder's director of risk management. "Then, we evacuate the building."

The order to evacuate is made by top management, but if a hurricane of a sufficient force is nearing the Miami area, the order is automatically made. "We treat hurricanes very seriously."

For example, Ryder ordered its headquarters evacuated last year, even though the approaching storm later veered off its course and hit the Florida Keys rather than Miami.

"The most critical thing is the employees. We don't want them in the building" if a hurricane threatens, even if it means a lost day of work, he said.

All companies also should examine each location for the likelihood of water damage, experts agree, adding that water damage can be more costly than wind damage.

"Water damage can be the biggest problem associated with a hurricane," said Mr. Hanneman. The force of water can "twist steel bars like pretzels."

Mark F. Wilson, corporate risk manager for First Mississippi Corp. in Jackson, pointed out that at a First Mississippi facility located on the Gulf of Mexico, electric motors in manufacturing plants are designed so that they can be removed and trucked inland if a hurricane threatens. "Often the motors are reinstalled before the electricity is back on," he said.

While water damage is most threatening to facilities along the coast, blowing water and flooding can ruin equipment and furnishings in the basement and first floor of buildings miles away from the ocean.

But while individual factors differ, the need for a written disaster plan is universal, experts say.

Mr. Goodwin, for example, suggests that the disaster plan can be issued as a stand-alone document or as an addendum to the company's risk management manual—as long as the plan is written.

Among other things, the disaster manual should spell out who performs what specific task before, during and after the disaster hits, Mr. Goodwin said, adding that an appointed damage control team—with clearly delineated responsibilities—should be given the responsibility for keeping the storm-related interruption of operations to a minimum.

Mr. Hanneman said that assigning specific people to tasks is most important. "You have to have a name. Don't assign a task to a department; put down a name," he said.

In addition, back-ups must be assigned, he said. "What if you are on vacation when the storm hits? There has to be someone there to pick up the gauntlet."

A key responsibility before, during and after a hurricane is communication with local police and fire departments and electric utilities, Mr. Hanneman said.

Keeping lines of communication open at all times formed the basis of the Westchester County, N.Y., disaster plan that was managed by Mr. Bieber. County officials, working out of a basement emergency headquarters, made sure that they could immediately contact contractors, public utilities, law and fire personnel and the National Weather Service during a hurricane.

The emergency headquarters served as "the eyes and ears of the county. It was the nerve center to interact with all the towns and villages of Westchester County," Mr. Bieber said.

The command center could tell personnel in the field where the worst problems were and dispatch police officers, firefighters and other emergency workers to deal with life threatening situations such as downed electrical wires. The emergency team also directed workers to points where trees blocked roads so that thoroughfares could be cleared.

Besides detailing how communications between the company and outside services should be conducted, the disaster manual needs to spell out what the company will tell both the press and its employees about the disaster, Mr. Goodwin said. An official spokesman should be designated so that misleading information is not accidentally released.

After the disaster, electronic data processing operations need to be brought back on line as quickly as possible to keep records current, Mr. Goodwin advised.

For EDP functions to continue, extra care must be taken to protect computerized operations from the wrath of the storm, pointed out T. David Phillips, an associate consultant with Crisis Management Corp. in Redondo Beach, Calif.

At Ryder, for example, computer facilities are grouped "in a central location—away from windows. And, you don't put your computers in the basement," Mr. McDonald said.

Experts also point out that hurricane winds increase the likelihood of power failure or power surges.

Power surges—unpredictable bursts of electricity that can wipe out data—present more complex problems than power interruptions. And, while equipment can be protected against surges, Mr. Phillips said risk managers must make sure that the right pieces of equipment are protected.

For example, a company might protect its main EDP center while ignoring minicomputers scattered throughout its operation. However, if the data on the minicomputers is destroyed, the mainframe cannot necessarily duplicate it, Mr. Phillips said.

Richard H. Soper, executive vp of Crisis Management Corp., added that the increased use of such machines as point-of-sale cash registers that independently track sales at a company's various stores and automatic teller machines at bank branch offices mean that risk managers have to devise contingency plans to convert to manual operations should a hurricane knock out satellite facilities.

Mr. Phillips emphasized the importance of adequately protecting communications equipment. Structural damage caused by hurricanes can sever wires inside walls, rendering both communications and computer facilities worthless.

Like Mr. Pouzer, Mr. Goodwin said that the risk manager has to make sure that emergency equipment works before the storm hits. He advocated checking stand-by generators and other essentials. Doing so, he said "can be a pain," and a risk manager may run into opposition from company officers who regard the exercise as a waste of time and money.

"It is expensive to slow down and check things out," Mr. Goodwin said. But, he said, it is considerably more expensive for a business to be knocked out of operation unnecessarily for weeks or months or even permanently shut down because emergency equipment did not work.

Other pre-disaster steps include working out arrangements with plate glass suppliers and other dealers in materials likely to be damaged in the storm for prompt delivery of replacements. There will be considerable demand for such materials, and well-thought-out agreements will help assure that the affected business will not have to delay reopening because of lack of supplies for repairs.

"Loose gravel will blow and break every glass object in sight," First Mississippi's Mr. Wilson warned.

While risk managers that do not have detailed disaster plans in place cannot be totally prepared when a hurricane strikes, there are several things a risk manager can do once he learns that a hurricane is approaching.

First and foremost, according to Florida Progress' Mr. Julien, is to "make sure coverage is in place" and is adequate to cover the loss. For example, make sure all endorsements to property insurance policies are properly worded so that hurricane damage is covered, he advised.

"That is No. 1. That is something you can do with a stroke of a pen. You have to insulate your company from the financial impact of a storm, Mr. Julien said.

"Check your policies," advised Mr. Goodwin.

The next step, especially if there is a problem with the coverage, is to "tell them there will be a financial impact" if the hurricane hits, Mr. Julien said. Once management learns there will be a loss, "they'll take the ball from the risk manager," he said.

"You may have 12 to 24 hours to react. You can get a lot done in that time," like sandbagging around facilities and moving important equipment and supplies to higher elevation to protect them from flood damage.

As with disaster planning, property insurance programs, of course, should be negotiated before a hurricane to cover the losses.

Most property insurance policies include coverage for wind damage, though the coverage is excluded from policies for some coastal risks, said Tony Abella, area vp at Arthur J. Gallagher & Co. in Miami.

If the windstorm damage is excluded, buyers usually must purchase the coverage from a state windstorm assigned risk pool, brokers say.

In addition, coverage for flood damage is excluded from most commercial property policies and must be purchased through the National Flood Insurance Program, Mr. Abella says.

And, Mr. Goodwin advises his clients to avoid renewals between June and December—the period in which hurricanes can occur—for two reasons.

First, "it's better to negotiate without a hurricane staring over your shoulder," he said, explaining it is tough for risk manager to negotiate property coverage at the same time a hurricane may be approaching.

Second, Mr. Goodwin notes, in tight markets insurers may not be able to offer sufficient capacity to insure a large property risk if the renewal occurs late in the year. "You should avoid shopping when the market's thinner."

Mr. Wilson advised risk managers who have never dealt with hurricane exposures to seek advice from other risk managers in the area.

"Learn from experience. You need to work with your peers and then develop the appropriate planning mechanisms to handle the risk," he said.

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Managing Editor James M. Burcke contributed to this story.

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Firms receive storm planning aid

HARTFORD, Conn.—In an effort to minimize hurricane damage to coastal industrial installations, Hartford, Conn.-based Industrial Risk Insurers advises its policyholders to follow a two-part hurricane preparedness checklist it devised in the early 1980s (*BI*, Sept. 9, 1985; March 22, 1982).

The first checklist spells out how to prepare for a hurricane's winds while the second deals with minimizing water damage. Some actions are repeated for both steps.

The Step 1 checklist includes:

- Shutting down operational processes safely.
- Inspecting roof edging strips, gutters, flashing, covering and drains.
- Inspecting sign and stack supports, guy wires and anchorages.

IRI urges that workers be especially careful as the eye of a hurricane passes over an installation because the winds can whip into another frenzy with little warning. Workers also need to be alert to the possibility of sudden flooding and ocean surge.

- Checking for weak door and window latches or for insecure panel fastenings.

These repairs should be made as quickly as possible to minimize further loss

- Protecting vulnerable windows from flying debris.
- Bracing unsupported structural members at construction sites.
- Protecting important records from wind, debris and rain.
- Updating important back-up records and moving them to a location not vulnerable to the same incident.
- Filling above-ground tanks to capacity with products or water to minimize wind damage.
- Anchoring movable structures and materials, such as trailers, lumber or any loose outdoor storage. These materials should be stored inside if practical.
- Assembling the following supplies and equipment at a central, secure location: Emergency lighting; lumber and nails; tape for windows; sandbags; roofing paper; caulking compound; tarpaulins; power and manual tools; shovels and axes; and chain saws.
- Ensuring that the emergency crew remaining on the premises has the following: non-perishable food; first-aid equipment; lighting sources; radio receivers; and stored drinking water.
- Filling emergency generator and fire pump fuel tanks.
- Inspecting all fire protection equipment to be sure it is in service.
- Taking extraordinary measures to secure outdoor traveling cranes and bridges. Besides setting rail clamps, secure these items with wedges and cable anchors.
- Cleaning out drains and catch basins.
- Being sure to prepare the flood checklist as well as the hurricane checklist.

The Step 2 checklist includes:

- Shutting down processes safely, and draining open tanks of flammable or combustible liquids.
- Bracing unsupported structural members at construction sites.
- Updating important backup records and moving them to a location protected from flooding.
- Anchoring outdoor items that can be moved by flood waters, such as trailers, lumber or loose storage. Move stored materials inside if it is practical to do so.
- Assembling all of the following types of supplies and equipment at a central, secure location: Portable pumps and hoses; emergency lighting; lumber and nails; sandbags, mops and squeegees; tarpaulins; power and manual tools; shovels and axes.
- Ensuring that the emergency crew remaining on the premises has the following: Non-perishable food; first-aid equipment; lighting; radio receivers; stored drinking water.
- Filling emergency and fire-pump fuel tanks.
- Checking travel brakes on moveable cranes and bridges. Anchor them in accordance with the manufacturer's out-of-service instructions.
- Placing sandbags at vulnerable openings. Water should be diverted from critical areas such as holes in foundations, doorways and sills.
- Moving machinery, stock and reports to higher elevations. By knowing the past flooding history of the area, reasonably safe areas can be selected.
- Shutting off all flammable and combustible liquid lines at their sources to prevent the discharge of such liquids from piping broken by floating debris. Exposed piping needs to be properly supported.
- Making sure both above- and below-ground tanks are properly anchored to prevent floatation. Empty tanks need to be filled with water or product and vent lines on active tanks should be extended above the anticipated maximum water level.
- Lashing down portable containers of flammable or combustible liquids.
- Shutting off electrical power at the main building when that building is in imminent danger of flooding.

IRI also urges that emergency workers be especially careful as the eye of a hurricane passes over because the winds of the seemingly calm storm can whip into another frenzy with little warning.

Workers also need to be alert to the possibility of sudden flooding and ocean surges.

After a storm has passed, damage—such as holes in walls or roofs—should be repaired as quickly as possible through temporary measures such as tarpaulins. Drains needs to be cleared of debris. And utility companies should be advised of necessary repairs and extra care should be taken to avoid downed power lines.

The IRI checklist was drafted by James A. Lambert, who retired earlier this year. Stan Couvillon, who succeeded Mr. Lambert, said the checklist "is all part of most large facilities' disaster plans."

—By Mark A. Hofmann



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Travelers projects losses with hurricane simulation

By MARK A. HOFMANN

HARTFORD, Conn.—When Don G. Friedman looks into the future, he consults no crystal ball. Instead, he gazes into a video display terminal to predict the fortunes of The Travelers Corp. and other insurers if a hurricane should strike.

By using state-of-the-art computer technology, Mr. Friedman—who holds a doctorate in meteorology from the Massachusetts Institute of Technology and is director of natural hazards analysis at Travelers' Natural Hazards Research Services unit in Hartford, Conn.—can predict how much damage a hurricane is likely to cause to insured property.

Among the data that Mr. Friedman feeds into his computer are: the point at which the hurricane touched land; the direction and curvature of its path; barometric pressure during the hurricane; the storm's speed; and the area covered by the storm. These factors help simulate maximum wind speeds generated by a hurricane, which account for much of a hurricane's destructive force.

The hurricane data is then synthesized with a geographic data base, which includes information on the number, value and type of property insured in nearly 30,000 cities and towns in 21 coastal states and the District of Columbia.

But the program cannot predict the damage likely to be sustained by specific structures, Mr. Friedman explained. Instead, "it's looking at a portfolio."

"The basic question is, 'what would happen to the present book of business if you had a recurrence of these hurricanes?' " he said.


Mr. Friedman

The computer program, which can simulate hurricanes that have occurred since 1871 with new property data, also can simulate hypothetical hurricanes.

In addition to predicting probable losses, the program allows Travelers to determine how many claims adjusters it will have to send to the devastated area.

But Travelers does not keep this information to itself, Mr. Friedman said. For the past 2½ years, the insurer has marketed its disaster analysis data through its Constitution State Management Co. unit, which currently is for sale.

Continued on next page

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Simulating storm damage

Continued from previous page

When Constitution State is sold, the loss forecasting service will be made available through another Travelers subsidiary, said John J. Mangano, assistant director of natural hazards analysis. He said that the number of clients, which include insurers and reinsurance brokers, fluctuates monthly.

Travelers is not the sole marketer of hurricane loss projection services. Minneapolis-based reinsurance broker E.W. Blanch Inc. has been selling its hurricane modeling service—CATALYST—since February 1987, said Frank Wilkinson, a general partner with Blanch. Blanch's service currently has about 30 subscribers.

Using historical data, CATALYST projects the frequency and severity of storms for a single area over a long period of time to help a client develop a catastrophe reinsurance program. The projections are updated annually to reflect changes in the client's book of business, such as changes in an insurer's exposures in a particular area, Mr. Wilkinson said.

But merely knowing the severity of a storm is less valuable than projecting how often a storm may strike a given site, he said. For example, a client facing the probability of weathering such a storm every two years has different needs than one that can expect such a catastrophe once every 2,000 years, he said.

Although hurricane loss projection services deal with hypothetical storms, Mr. Friedman said: "For most insurance questions, the projections certainly have been accurate enough."

To verify projections, the Travelers researchers have run simulations of actual disasters through the program, and then compared simulated storm damages against actual tallies of insured losses prepared by the Property Claims Services division of American Insurance Services Group Inc.

The development of the hurricane model began more than two decades ago, Mr. Friedman said. Mr. Friedman, who has been with Travelers since 1955, acted as a consultant to the federal Department of Housing and Urban Development during the mid-1960s when HUD was involved in the creation of the National Flood Insurance Plan.

Mr. Friedman created a model that simulated what he called "synthetic experience," showing what would have happened had properties at 5,500 different locations been inundated with floods of various magnitudes. He used the model to explain the proposed insurance program to Congress, which later approved the National Flood Insurance Act in 1968.

The All-Industry Research Advisory Council—an insurance industry research organization based in Oak Brook, Ill.—in the early 1980s sought to determine what financial impact two hurricanes, each causing $7 billion in insured losses, would have on the insurance industry (see related story). Mr. Friedman used a computerized mapping system to project the damages.

The map used a grid that divided the United States into 65,000 separate areas, each about 35 square miles. The researchers next added census data on population and the number of single family dwellings in each block, and then added estimates of insured commercial properties.

Two hypothetical hurricanes were entered into the system. One followed the path of Hurricane Alicia, which struck the Houston-Galveston area in 1983. The other, which made landfall in Florida and New England, replicated the path of 1960's Hurricane Donna.

AIRAC used the models to calculate losses by state, by line of business and by individual insurer, with the insurer's losses determined on the basis of each insurer's statewide dividends. More than 300 primary insurers were asked to provide confidential information on the amount of losses they would pay from their own resources as well as the amount and sources of their reinsurance. Some 112 insurers—which collectively covered about 75% of the losses caused by the computerized storms—responded. The results of the test were released in 1986.

The disaster analysis team also examines probable earthquake losses by using a program similar to the one that predicts hurricane damage. The earthquake program takes into account the power of the tremor as measured on the Richter Scale, the type of soil in the area, the pattern of fault lines under the site and the depth of the quake's epicenter.

Since his first simulations for the National Flood Insurance Program, techniques have gone "from slide-rule to PC," said Mr. Friedman. But, despite the strides in electronic modeling, he sees no end to fine-tuning the loss-projection maps. "They're never completed," he said. ■

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Huge storms would devastate insurers

By MARK A. HOFMANN

The first hurricane blasted the Gulf Coast from eastern Louisiana to south-central Texas, venting the brunt of its fury on the Houston-Galveston area. The storm caused $7 billion in insured damage.

Thirty days later, another tempest ripped northwestward across South Florida, twisted to the northeast near Tampa Bay and continued northeastward along the Atlantic coast, making landfall on Long Island before crossing over Providence, R.I., and Boston. It, too, caused $7 billion in insured damages.

Fortunately, those devastating hurricanes occurred only in the bowels of a computer used to determine the effect the storms would have on insurers and reinsurers.

The outcome: Two hurricanes causing $14 billion in insured damage would rob U.S. property/casualty insurers with hurricane exposures of 13.3% of their surplus. In addition 28 underwriters—six U.S. companies and 22 foreign companies—would face claims exceeding their surplus, plunging them into insolvency without transfusions of large amounts of new capital.

While a hurricane causing $7 billion in insured damage has never hit the United States—the most costly storm to hit the U.S. mainland, Hurricane Alicia, in 1983 caused $1.3 billion in insured losses—insurers say such costly storms now are possible because of development along the Gulf and Atlantic coasts.

"Two successive catastrophes of the magnitude hypothesized in this study would do severe damage to the property/casualty insurance industry in the U.S. and abroad," concluded the 1986 report "Catastrophic Losses: How the Insurance System Would Handle Two $7 Billion Hurricanes," prepared by the All-Industry Research Advisory Council, an insurance industry-supported research organization based in Oak Brook, Ill.

"It's a little difficult to know what the impact of such storms would be today," said AIRAC Executive Direc-

Continued on next page

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Continued from previous page

tor Donald W. Seagraves, explaining that the data was based on questionnaires filled out in 1984.

While insurers' surpluses generally have increased since 1984, Mr. Seagraves pointed out that many insurers now retain more risk, which would amplify the effects of two colossal storms. At the same time, some companies also fear that they will not be able to collect on their reinsurance, he added.

Further complicating matters is a constantly expanding exposure. The value of structures has increased as more buildings are being added to the crowded coastlines.

While the AIRAC study is considered the most authoritative research into the potential extent of insured losses caused by a series of massive hurricanes, many observers admit that insurers cannot realistically estimate the risk posed by hurricanes.

C. Edward Hermanson, vp in the Property Claims Service division of the American Insurance Services Group in Rahway, N.J., agreed that there is no way to determine insurers' overall hurricane exposure, but he added that the exposure is increasing with the development—and in many cases overdevelopment—of coastal areas.

"It's traditional for people in this country to move toward the water," regardless of the increased chances of loss, Mr. Hermanson said.

Without adequate hurricane protection measures, including enforcement of building codes and development of evacuation plans, high-density coastal development "in terms of human lives is a tragedy in the making," he said.

"The situation is definitely getting worse," said Orrin Pilkey, professor of geology at Duke University in Durham, N.C., and a critic of dense coastal development. "The problem is increasing dramatically."

According to the AIRAC study, primary insurers—all based in the United States—would pay $4.9 billion of the $14 billion in insured damaged caused by the two hypothetical hurricanes. The rest would be paid by reinsurers: $2.5 billion by treaty reinsurers, $546 million by facultative reinsurers and $6.1 billion by retrocessionaires.

Some 57.6%—or $7.7 billion—of the $14 billion loss would be paid by U.S. insurers and reinsurers, 15.1%—or $2 billion—by Lloyd's of London underwriters, 13.7%—or $1.8 billion—by other U.K. insurers and 13.6%—or $1.8 billion—by other insurers around the world.

AIRAC says that 112 U.S. primary insurers would sustain losses because of the storms, six of whose net losses from the hurricanes would exceed their entire surpluses. In addition, another six primary insurers would have net losses exceeding 50% of surplus. In all, U.S. primary insurers with storm losses would lose 11.1% of surplus as a result of the storms.

The study assumed that insurers would have the full limits of reinsurance treaties available to pay hurricane losses. However, "although relatively few U.S. companies would have been plunged directly into insolvency by these two storms alone, others might have failed because of the inability to collect reinsurance or the inability to take credit for some of their reinsurance," the study points out.

The effect of the storms on reinsurers would be even more devastating: U.S. professional reinsurers' net storm losses would equal 34.4% of surplus, according to AIRAC, while Lloyd's syndicates' net losses would equal 41.4% of surplus.

In addition, AIRAC estimates that 22 reinsurers—all foreign—would sustain net losses exceeding their surplus.

Continued on page 27

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Business Insurance Circulation Breakdown* Commercial Consumers

Administrative:	
CEO's Presidents and Owners	2,621
Vice-Presidents, General Managers and Other Administrative Personnel	3,657
Financial:	
Chief Financial Officers and Vice-presidents of Finance	2,993
Secretaries, Treasurers, controllers and other Financial Personnel	4,454
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	10,994
Sub-total	**24,719**
Associations	477
Government, Unions and Educational Institutions	979
Commercial Consumers Sub-total	**26,175**
Insurance Agents and Brokers	10,557
Insurance Companies	7,380
Actuaries, Attorneys, Adjusters, Appraisers and Consultants	3,843
Others Allied to the Field	2,991
TOTAL	**50,946**

* Source Business/Occupational breakdown of qualified circulation, May 30, 1988 issue, as submitted to BPA for June 1988 BPA Publisher's Statement.

Hurricane costs

Continued from page 25

"It is highly probable that significant amounts of reinsurance would not be collectible and that additional losses would fall back onto the shoulders of the ceding reinsurers and primary companies," the study notes.

While a worst-case series of storms would have a definite devastating impact on the insurance industry, Dean R. Flesner, chairman of the National Committee on Property Insurance's windstorm and coastal issues committee, points out that a single Force 5 hurricane packing winds of more than 155 mph would not likely have a catastrophic impact on property/casualty insurers.



Mr. Lecomte

Mr. Flesner, who is also vp-operations for State Farm Fire & Casualty Co. in Bloomington, Ill., said there could be some insolvencies, in part due to uncollectible reinsurance, but they probably would not be widespread. The major impact most likely would be reduced capacity throughout the industry.

"Our biggest exposure is not necessarily one storm—it's a combination," Mr. Flesner said.

One way insurers can help lower their astronomical exposures is through encouraging better building and land management practices.

"Insurance companies have done so much from the standpoint of encouraging seat belt use and discouraging smoking that maybe they could do the same thing in coastal areas by coming up with a game plan that would promote things that would promote safer development," Mr. Pilkey aid.

Among Mr. Pilkey's suggestions were: encouraging greater setbacks for coastal construction; discouraging dense development on barrier islands; encouraging the movement of vulnerable properties further inland; and even publishing maps of high- and low-risk coastal regions.

AIRAC currently is undertaking a study of how the enforcement of building codes in coastal areas affects storm worthiness.

"If you allow people to build in an area known to be prone to erosion, you've got a guaranteed claim," Mr. Seagraves said. In some cases, municipal governments ought to buy up beachfront and turn it into parkland rather than allow the construction of commercial or private structures that are doomed to short lives.

At least one state residual market property insurance pool is attempting to reduce hurricane damage exposures through tighter construction requirements.

In an effort to minimize hurricane-caused damage, the New York Property Insurance Underwriting Assn. last month announced new eligibility standards. Properties built on a barrier island or within 1,500 feet of the ocean will have to be inspected by licensed architects or engineers. The inspectors will certify whether or not the property meets windstorm resistance standards.

Properties that fail the tests will have to be upgraded, said Michael Eserner, assistant vp-underwriting at the NYPIUA.

Owners will have 90 days from the time the fault is discovered to rectify the problem or to embark on a larger scale improvement program. Property owners who refuse will lose their coverage.

The NYPIUA plan already has come under fire from J. Robert Hunter, president of the Alexandria, Va.-based National Insurance Consumer Organization, who claims that the retroactive construction requirements are designed to deny coverage to some people.

Mr. Eserner denies the charge.

Insurers are not deliberately trying to exclude anyone from the market, adds Mr. Flesner. "From an industry standpoint, it's our job to provide coverage. Collectively, we need to find a way to keep the market open."

Eugene Lecomte, NCPI's president, said that insurers cannot control, and cannot be expected to control, all of the factors that increase the nation's hurricane exposure. "It's not really our problem to solve; it's society's problem to solve," he said.

One way society has attempted to diminish hurricane losses is by passing coastal land use acts.

Both Mr. Pilkey and Mr. Hermanson cited the North Carolina Coastal Area Management Act of 1974 as an example, perhaps the best example, of a successful shore land use plan. By requiring strict setbacks and special building codes for areas likely to experience high-velocity winds, the state has been able to mitigate hurricane damage.

For instance, North Carolina, with its relatively stringent building code, has fared much better than Texas, which had few building requirements, when hit by hurricanes of a similar force, according to a 1985 study by researchers at North Carolina State University and Clemson University.

While property loss control experts agree that the absence of adequately enforced building codes in many coastal areas and the steady migration of people and property to hurricane-prone regions have clearly added to the insurance industry's hurricane exposures, many worry even more about public complacency over the threat to life and property posed by the storms.

"Our fear from an industry point of view is that people might not pay attention to a hurricane warning," Mr. Hermabson said. "People don't recognize the force of a hurricane," he said, noting that no truly disastrous hurricane has hit the Atlantic Coast in years. ■

AHA study

Continued from page 3

- Employers, health care providers and government should subsidize coverage for low-paid employees (see story page 28).
- Insurers should design a less expensive product or delivery mechanism to make coverage more accessible to employers and their workers.
- Insurers should increase product awareness and employers should educate workers about their coverage options.

According to the study, businesses that do not offer health care coverage often share one or more of the following characteristics:

- The employees have low salaries—75% of workers without health insurance earn less than $10,000 annually and 93% of uninsured workers earn less than $20,000 a year.
- The business is small and is therefore at a disadvantage in purchasing insurance.
- The firm is unincorporated and therefore disadvantaged by current tax laws.
- The firm is in an industry, such as retail, where coverage is not common.

However, the businesses that do offer health insurance often have eligibility requirements for workers to obtain coverage, the most common of which is that employees work full time. According to the U.S. Small Business Administration, 49% of firms with part-time employees exclude these employees from their health care plans.

The primary reason why uninsured employees reject employer-provided health coverage is they cannot afford it. A 1987 study conducted by the Service Employees International Union found that 48% of uninsured workers had been offered, but rejected, employer-sponsored coverage because they thought it was "too costly."

In addition, Ms. Fraser wrote, employers that offer family coverage have been reducing the percentage of premiums paid for dependent coverage, resulting in greater premium costs to employees (*BI*, July 4).

However, the study also stated that about 13% of employees that reject employer-provided insurance do so because they already have coverage. "One very practical reason for rejecting insurance is possession of indirect coverage from another source, particularly if the other source provides better coverage or lower employee costs," Ms. Fraser explained.

Ms. Fraser also said that the insurance industry differentiates between large and small groups. "The insurance system works better for some employers than for others," she wrote.

The study points out that it is more difficult for small employers to offer coverage than for large employers that can reap economies of scale.

The report stressed that the disadvantages of small firms are a straightforward consequence of size itself. For example, marketing and servicing a health insurance account entails certain fixed costs, which are spread among a large number of subscribers in large groups, but only a small number in small group plans.

The study adds administrative services to the list of small business woes. Where large groups typically have a benefits administrator who answers employee questions, keeps track of enrollments and disenrollments and performs many other administrative tasks, small groups typically lack a person in that role. Therefore, the insurer performs these functions and builds the cost into the premium structure.

Another factor affecting the premium is risk selection. In a large employer group, particularly one in which the employer pays the entire premium, the costs are spread among the large base of employees.

In a small group, one unforeseen serious illness can convert a moderately profitable contract into a very unprofitable one for an insurer, according to the report.

In addition, small groups are perceived by insurers to be unstable because:

- Small firms are less likely to stay in business than large firms. When a small business fails, the insurer may be unable to collect unpaid premium dollars.
- Small firms have higher employee turnover, which translates into higher administrative costs.
- Small employers are more likely than large employers to change insurers from one year to the next.

But the study also points out that uninsured workers are not strictly a phenomenon of small business. Citing a U.S. Small Business Administration study, the AHA found that while 48% of uninsured workers were employed by firms with fewer than 25 employees; 15% are employed at firms with 25 to 99 employees; 12% are employed at firms with 100 to 499 employees; and 26% are employed at firms with more than 500 employees.

"In order to have affordable coverage for everyone, the public component needs to be strengthened," Ms. Fraser said in an interview.

Expansion of state Medicaid programs may be the most appropriate and effective way to increase coverage for families undergoing a transition from welfare to work or for other very low-income families unable to contribute much toward a premium, Ms. Fraser wrote.

●

Single copies of the study, "Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage" are available free from Rosa Guerrero, American Hospital Assn., [illegible] N. Lake Shore Drive, Chicago, Ill. 6[illegible] 280-6325.

Risk Manager of the Year Award

Continued from page 3

Nominations must be submitted according to the detailed instructions contained in a special nominating form available from the *Business Insurance* editorial office in Chicago.

The deadline for submitting nominations is Nov. 23.

The 1988 Risk Manager of the Year was William L. Mather, administrator of risk management for The Gillette Co. in Boston (see box for other past winners).

Members of the 1988 Risk Management Honor Roll were:

- Gregory L. Daniels, director of the Risk Management Division at The American National Red Cross, in Washington, D.C., representing tax-exempt and not-for-profit institutions.
- Stephen A. Finley, risk manager for the city of Lakewood, Colo., representing government entities.
- Timothy G. Galarnyk, corporate safety engineer and risk manager at Lunda Construction Co. and Phoenix Steel Inc. in Black River Falls, Wis., representing corporations with less than $300 million in sales.
- Edward G. Weiss, director of risk management and security at First of America Bank Corp. in Clawson, Mich., representing financial institutions.

To nominate a candidate for the 1989 Risk Manager of the Year Award, request a special nominating form by writing: *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590.

Information supplied in the nominating statement, which must be endorsed for its accuracy by the candidate's superior, will be kept in strictest confidence. Only the names of the winners will be announced. ■

10 criteria used for judging nominees

Ten criteria will be used to score the nominations submitted for the 1989 *Business Insurance* Risk Manager of the Year Award and Risk Management Honor Roll.

The 10 independent judges of the annual competition will score each candidate on a scale of one to 10 according to how well he or she:

- Established and implements an effective risk management program within the organization.
- Tackled and solved one or more major problems for his or her organization.
- Innovatively applies the diverse tools of risk management and insurance.
- Creatively and effectively uses the insurance markets to structure an insurance program that serves the needs of the organization. (This criterion specifically addresses the types of policies purchased and manuscripted policies, if any, developed.)
- Established a workable intelligence system inside and outside the organization that culminates in a flow of information about events and activities that affect the organization's risk management and insurance. (How the risk manager secures information on risks from other departments and the use of risk management information systems are addressed in this criterion.)
- Skillfully performs the functions of management in the overall organization and within the risk management/insurance department. (The functions include planning, organizing, directing and controlling.)
- Achieves the most effective program at the optimum cost over the long term.
- Developed technical expertise in any or all of the broad categories included within risk management, leading to a better managerial grasp of the operations aspects of the job.
- Exhibits an attitude and performs activities fostering the advancement of the risk management profession (such as professional activities, speaking engagements, teaching and related activities).
- Develops in his or her career (as exhibited by job history, including current job description, education, honors and memberships). ■

Risk managers of the yea[r]

William L. Mather Administrator of Risk Management The Gillette Co.	19[illegible]
Edith F. Lichota Senior Vp Irving Trust Co.	1987
Donald Nelson Director of Risk Management ARA Services Inc.	1986
Harold C. Lang Director of Insurance and Risk Management Leaseway Transportation Corp.	1985
Richard M. Inserra Director of Insurance and Risk Management American Can Co.	1984
John A. O'Connell Executive Director and Risk Manager Holy Cross Shared Services Inc.	1983
Eckhart Russell Risk and Insurance Manager Alcan Aluminium Ltd.	1982
Duane E. Allen Assistant Treasurer Hanna Mining Co.	1981
Thomas V. Hallett Risk Manager General Motors Corp.	1980
Edward L. Erickson Director of Insurance American Broadcasting Cos. Inc.	1979
Howard T. Weber Director of Insurance Minnesota Mining & Manufacturing Co.	1978

Pilot plans seek to boost worker coverage

By BRIGITTE MAXEY

Nearly one-fourth of the states are experimenting with programs aimed at improving workers' accessibility to health insurance, the American Hospital Assn. points out in its study of the uninsured.

Funded by the Robert Wood Johnson Foundation, a health care philanthropic organization, the programs in Arizona and Michigan focus on two types of workers: those employed at small businesses and former federal aid recipients who are newly employed.

The foundation turned to the Alpha Center in Washington, D.C., a non-profit health policy and planning organization, to provide technical assistance for the programs.

"Arizona and Michigan are representative of different strategies being tested under the uninsured programs in 12 states," said Randolph Desonia, program analyst at the Alpha Center.

"During this (demonstration) phase we will apply different strategies and find out which ones work and why," said Mr. Desonia.

Under the Arizona plan, participants are offered a gamut of health insurance plans with varying prices and benefit levels.

Employers in Tucson and Phoenix with 25 or fewer full-time employees are eligible to participate if the employer has not offered group health insurance in the previous six months. Employer contributions to workers' premiums, although encouraged, are not mandatory.

Although the program does not increase insurance affordability, it addresses the problem of availability of health insurance by offering a prepackaged managed care product to employees.

"The insurance project for small employers provides insurance availability," Mr. Desonia said, pointing out that the market for small group health insurance in Arizona is limited.

Coverage under the program is provided through existing prepaid managed health care plans the state already uses for Medicaid recipients.

"So far, we have over 100 firms active in the program, which is a little under our expectations. The No. 1 problem is the inability to get more managed care providers in Phoenix," said Mr. Desonia.

The "Health Care Group" program offers employees four plans:

- Option I offers a maximum annual benefit of $250,000, with policyholder copayments limited to $10 for office visits, $5 for prescriptions and $50 for emergency room treatment. In addition, employees are responsible for 20% of inpatient hospital services up to a maximum set by each plan.

There is no deductible under this option. The cost for single coverage averages $60 per month.

Premiums for all four insurance plans are set on a community rating by class basis, which takes into account the aggregate age of the group of employees enrolling.

- Option II also offers a $250,000 maximum annual benefit. Policyholder copayments for office visits, prescriptions and emergency room treatment are half of the copayments for Option I. In addition, the Option II plan pays 100% of total hospital care.

Single coverage premiums range from $69 to $136 per month depending on the average age of the employee group.

- Option III has an annual benefit limit of $20,000 and pays 100% of all covered hospital inpatient and outpatient services. Only emergency room treatment requires a $25 copayment per visit.

Premiums for single coverage range from $60 to $160 per month depending on the age of the group.

- Option IV offers a $250,000 per year maximum benefit, but enrollees must pay the first $2,000 of medical/surgical charges. The plan covers 100% of additional charges.

The premium for single coverage averages from $32 to $95 per month depending on the age of the group.

Michigan's approach to helping the uninsured find coverage, the "One-Third Share Plan," is available to former recipients of federal aid who are now employed.

"Ex-recipients usually enter into low-paying jobs and are financially unable to pay the cost of insurance. This program is subsidized by the state government and allows them (workers) to obtain coverage," said Mr. Desonia.

The pilot, which requires employers to pay one-third of an employee's premium, is operating in urban Genessee County and rural Marquette County. To be eligible, an employer may not have offered group health care coverage in the past two years and must hire at least one former welfare recipient.

Employees with incomes of up to twice the poverty level—which is currently $11,850 for a family of four—can receive a state subsidy toward premiums.

For employees earning between 101% and 200% of the poverty level, the state, the employer and the employee each pay one-third of the premium. For employees with incomes below the poverty level, the state pays two-thirds of the premium and the employer pays the remainder.

The coverage and premium requirements for the program are based on provisions in the Blue Cross/Blue Shield traditional indemnity plan in each county or the BC/BS-sponsored Blue Care Network HMO, where available. Employers may purchase other coverage, but services and costs must meet program specifications.

The 33.3% share of the employee-paid monthly premium currently is limited to $26.64 for individual coverage and $66.60 for a family of three or more.

To be eligible for the program, annual deductibles cannot exceed $100 per individual or $200 per family; copayments generally cannot exceed $5 to $10 per service, or 20% for major medical benefits; and annual out-of-pocket payments cannot exceed $2,500.

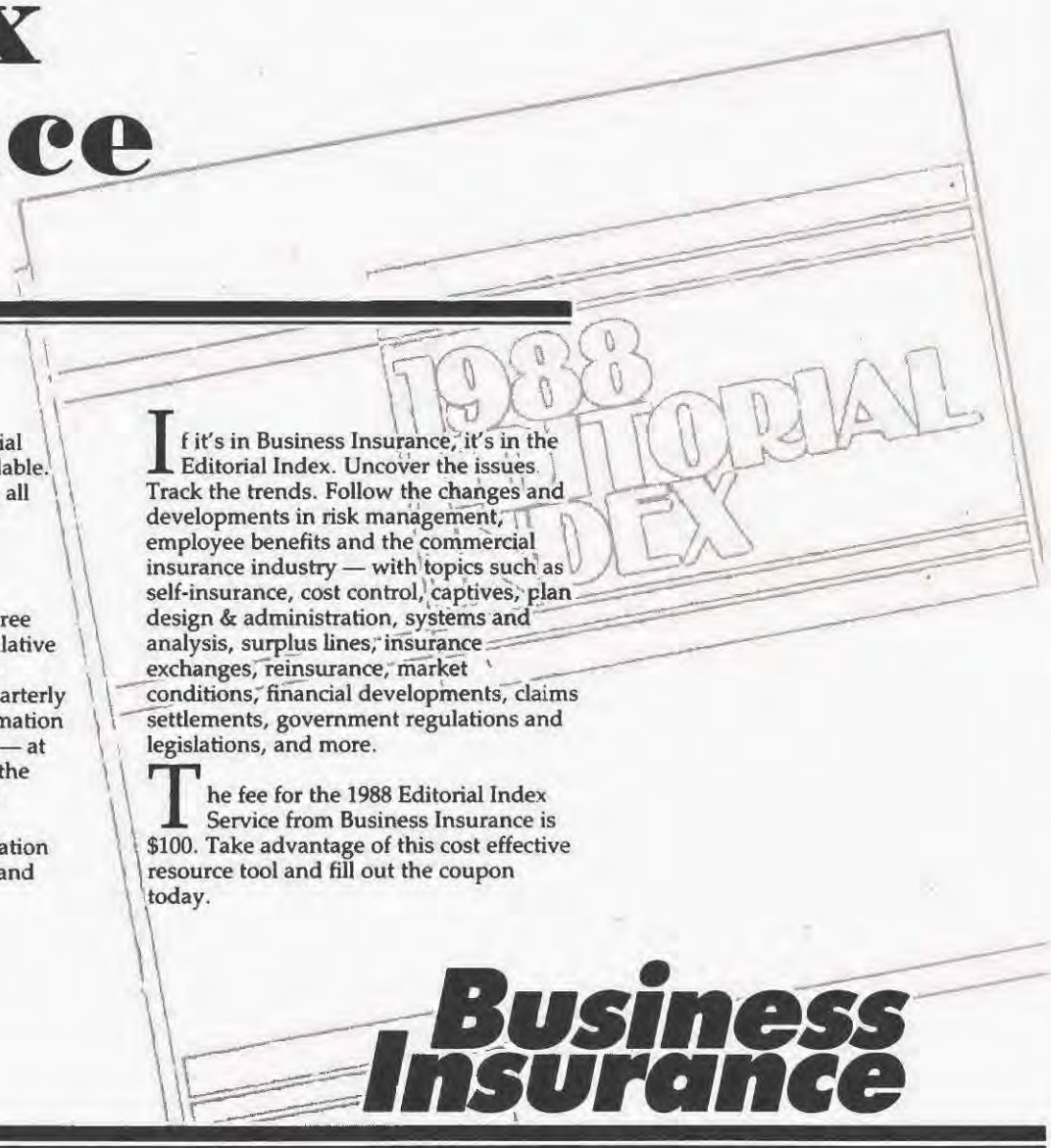
The goal of the program is to encourage employers to continue offering health care coverage after the pilot ends in 1989. "This way, the employer gets to purchase health insurance that's already on the market and does not have to implement new programs for his firm," Mr. Desonia explained.

In addition to former public aid recipients, other low-income workers at participating employers are eligible.

"In some situations the co-workers of the ex-recipient (of aid) think that it is unfair for the new worker to receive coverage when they themselves earn too low of a wage to purchase insurance.

"The government will subsidize health insurance premiums for up to 20 co-workers per firm," who meet the program's eligibility requirements, Mr. Desonia said. ■

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Business Insurance

Work comp suit

Continued from page 4

About 85% of cases that are taken to hearings involve contested claims for permanent disabilities, which are more complex than many other injury cases, he said.

But Mr. Azevedo disagrees, contending that many injured workers are forced to seek legal help when the workers compensation system does not respond promptly as required by law.

The lawsuit was brought by California Rural Legal Assistance and Mr. Azevedo on behalf of three individuals:

- James Sheppard, 53, who suffered extreme lower back pain in 1983 that renders him unable to perform physically strenuous work. He also suffered related cardiovascular and psychological injury, according to the claim. Thus far, he has been denied medical expenses by his employer, Greyhound Bus Lines Inc.
- Violet Day, 41, who was working as a waitress in a Madera restaurant when she slipped in July 1986 while carrying a heavy tray into a walk-in refrigerator. She continued to work out of economic necessity but quit later when she no longer could perform the duties of her job and applied for workers compensation in January 1987. She subsequently was enrolled in a rehabilitation program. But she quit the program five months later after her weekly $112 benefit payments were canceled when the industrial relations division determined she was ready to return to work.
- Robert Price, 54, who had been a construction worker. He was injured in April 1987 while doing masonry work for a Madera contractor. In May he accepted a $6,200 settlement offered by the former employer's insurer, which was reached without the approval of a workers compensation judge as required by state law.

Mr. Azevedo said that as many as 20 other plaintiffs may join the lawsuit based on reaction to recent publicity about the matter.

No hearing or trial dates have been set. ■

California legislators unlikely to OK work comp reform bill

By GLENN HUNTLEY

SACRAMENTO, Calif.—Efforts by California legislators to reform the nation's largest workers compensation system have ground to a halt, and observers doubt that the Legislature will pass a reform bill before it adjourns next week for the year.

Since April, a conference committee has been attempting to hammer out a reform bill—with the aid of labor, employers, insurers and a state commission—that would increase benefit levels without increasing employers' costs (*BI*, April 11).

But, because of a lack of progress, the conference committee has not scheduled any more sessions before the Legislature adjourns Aug. 30 and will not resume work on the bill "unless they have something to do," said Casey Young, consultant to the Senate Industrial Relations Committee.

"Something" that could move the reform effort along would be concessions by any side on the "big money issues." Those issues include establishing uniform standards for vocational rehabilitation programs, eliminating the inequities in weekly benefits paid to lower-paid and highly paid employees, defining what constitutes a stress-related claim, reducing delays in providing benefits to injured workers and defining which injuries constitute stress injuries.

"At this time, stay tuned. There's not a lot of time left. Someone has to make a move," Mr. Young said.

California's workers compensation system has been hit by skyrocketing costs over the last five years, while the maximum weekly benefits to injured workers have remained among the lowest in the country, according to the Commission on California State Government Organization and Economy.

California employers paid $6.4 billion in direct written work comp premiums in 1987, up 120% from $2.9 billion in 1982, according to the California Workers' Compensation Institute.

Odds are "slim" that an agreement on a single reform program can be reached by Aug. 30, said Jose Hermocillo, executive director of Californians for Compensation Reform, a coalition of trade groups that has pushed hard this year for reform legislation.

"Everything is up in the air," he said.

However, Mr. Hermocillo believes a compromise can be reached. "I think we can work it out. I keep waiting for the right dynamics to happen," he said.

The California Chamber of Commerce also has supported workers comp reform for several years only to meet with frustration, said Roberta Cook, counsel for insurance and employee benefits.

"We're still hopeful," Ms. Cook said. "I think everyone still hopes" for a last-minute compromise.

The political debate in California over workers comp reform likely will continue for another year, because Gov. George Deukmejian has tried for six years to get the Legislature to pass workers comp reform he could support, said Ronald Rinaldi, director of the state Department of Industrial Relations.

Gov. Deukmejian vetoed a workers comp package in 1985 that would have increased benefits, because the reforms failed "to neutralize employer cost, diminish administrative costs and reduce the amount of litigation" (*BI*, Oct. 14, 1985).

Meanwhile, an informal task force organized by Gov. Deukmejian has agreed on some workers comp reforms. Its conclusions, however, are not binding on the conference committee.

Areas in need of reform, according to the task force, include:

- The Department of Industrial Accidents. The task force recommends that a new Division of Workers Compensation replace the DIA, with the new agency assuming all of the duties of the existing agency. The DWC also would assume all of the Workers Compensation Appeals Board's procedural rule-making authority.

The new division would be split into three offices that would handle benefit assistance and enforcement, benefit determination and claims adjudication.

- Enforcement of the law. New civil penalties are needed against employers when the DWC discovers violations of the state's workers comp code during employer audits. The penalties would range from $100 per violation to $5,000 per audit.

The commission also recommends civil penalties of up to $50,000 for findings of patterns of misconduct in delivery of benefits.

- Permanent partial disability benefits. Employees with more serious disabilities should receive higher benefits. However, no agreement was reached on maximum or minimum benefits.
- Awards of permanent disability benefits. The awards should be reviewed by the DWC's administrative director, who could consider "objective" factors affecting the employee's ability to compete in the labor market in addition to the nature of injury, a worker's age and occupation when determining percentage of disability. The commission did not define "objective factors." ■

AIG unit settles suit for $7.5 million

By MICHAEL BRADFORD

AUSTIN, Texas—A toy company's insurer has reached a settlement valued at $7.5 million with the parents of child who was struck by a car while riding a tricycle manufactured by the company.

The settlement will be funded with an annuity from National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc. in New York, according to a spokeswoman for Brown Group Inc. Brown Group owned Hedstrom Co., which manufactured the tricycle, at the time of the 1983 accident.

The settlement resolved a suit filed by the injured child's parents, who claimed that because the tricycle was dark-colored, it was not highly visible to the driver of the car that hit the boy.

The suit, filed in 1984 in state District Court in Travis County, Texas, charged Hedstrom was negligent in manufacturing a tricycle that was "defectively designed because of inadequate conspicuity," said Hedstrom attorney Jack Latson, who is with the Austin, Texas, firm of Flahive, Ogden & Latson.

The accident occurred when George Smith, now 9 years old, rode his bicycle into a street and was struck by a car, Mr. Latson said. The boy was struck by the car "in broad daylight, about 4 p.m.," while riding a black tricycle, he said. No charges were filed against the driver in the accident, which left the child with traumatic cerebral palsy.

The settlement totaled $960,000 in cash. The annuity cost $560,000 and $390,000 was paid in attorneys fees and medical expenses. Another $10,000 was paid to the parents by the driver's insurance company, Dairyland Insurance Co., a Century Insurance Group subsidiary based in Scottsdale, Ariz.

Not naming National Union, Mr. Latson said the case was settled because the insurance company feared having to pay a large verdict if the case were resolved by a jury. The company has paid large judgments before in Texas and is "paranoid about trying to litigate in this state," he said.

In fact, high verdicts in "the more liberal counties have made (all) insurance companies very wary" about litigating cases in Texas, according to Mr. Latson.

The settlement was signed in late July by state District Court Judge Paul Davis. It is structured to make escalating monthly payments to the boy until he is 72, the Brown Group spokeswoman confirmed. ■

Update

Raymark free to sue attorneys

Continued from page 2

Raymark charges that the two attorneys organized and financed the National Tire Workers Litigation Project, which Raymark says performed "phony or inadequate medical examinations" on workers who might have asbestos-related injuries (*BI*, Oct. 5, 1987).

Mr. Gerry denied the allegation, saying that he and Mr. Stemple "agreed to work together on behalf of these people" after the attorneys had been asked to do so by local unions. Messrs. Gerry and Stemple sought to have Raymark's suit dismissed. "We thought their complaint was defective," Mr. Gerry said.

Maxicare Utah unit closed

SALT LAKE CITY—Maxicare Health Plans Inc., an ailing Los Angeles-based health maintenance organization, is closing its Utah operation, citing losses totaling about $5 million since the Utah plan was launched in 1982.

Under an arrangement implemented by Utah Insurance Commissioner Harold C. Yancey, other HMOs in the state have until Sept. 1 to market their plans to Maxicare's 20,000 Utah subscribers. The Insurance Department will then apportion remaining Maxicare subscribers among other HMOs in the state.

The Utah shutdown came just a week after Maxicare directors ousted co-founders Fred W. Wasserman, chairman, and Pamela K. Anderson, president, following 18 months of losses (*BI*, Aug. 15).

The HMO failed in attempts to find a buyer for its Utah unit. Losses in Utah were attributable to offering coverage for pre-existing conditions, a high use of obstetric care and failure to negotiate sufficient discounts with hospitals, a spokeswoman said.

Lloyd's syndicate subdivides

LONDON—Lloyd's of London's largest syndicate 418/417 is being divided for underwriting and administrative purposes into three divisions, its managing agency Merrett Underwriting Agency Management Ltd. announced last week.

Although syndicate 418 will remain the general umbrella name for the "group" and Stephen Merrett will remain group underwriter, the syndicate will have three units, each with its own number.

According to a letter from Mr. Merrett to Lloyd's members agents:

- One unit underwritten by Mr. Merrett and deputy underwriter Barnabas Hurst-Bannister will write oil, professional liability, aviation product and space coverage while also developing new business ideas.
- One unit underwritten by Tim Jonas will write cargo and specie (currency and bullion), hull and aviation business.
- One unit underwritten by Dennis Purkiss will write marine and non-marine excess-of-loss reinsurance. Mr. Purkiss also will remain underwriter for syndicate 421 managed by MUAM.

PEPCO eyes appeal of award

UPPER MARLBORO, Md.—Potomac Electric Power Co. says it will appeal a $7.8 million jury award to the estate and family of a girl who was electrocuted in 1986 by low-hanging power lines if the judge in the case lets the verdict stand.

A Prince Georges County, Md., Circuit Court jury on Aug. 16 ordered PEPCO to pay $7.5 million in punitive damages to the estate of girl and $350,000 in compensatory damages to the girl's parents. The jury originally had awarded $500,000 in pain and suffering damages, but non-economic damages are capped at $350,000 under state law.

However, a spokeswoman for Washington-based PEPCO said the judge failed to inform the jury about a Maryland law under which people are presumed to know that utility power lines are electrically charged. As a result, "the verdict is faulty," she said. The girl was killed when she touched the power lines in Forestville, Md.

The entire verdict, except for a $500,000 deductible, would be covered by the utility's insurer, Bermuda-based Associated Electric Gas Insurance Services Ltd., a utility group captive.

AIG sues former vp for fraud

NEW YORK—American International Group Inc. is suing a former officer for allegedly embezzling more than $1.7 million between 1983 and 1988.

AIG filed a civil complaint in New York State Supreme Court in Brooklyn last month against Robert M. Guarnaccia, former vp of AIG subsidiary American Home Assurance Co.

The complaint says Mr. Guarnaccia, who was fired last month, defrauded AIG by creating phony invoices from an inspection company working for the insurer, then depositing payments he had authorized in a bank account he controlled.

Mr. Guarnaccia has denied the accusations and has filed a $500,000 counterclaim against AIG.

Briefly noted

Chubb Corp. is 80% reinsured in the London market for only the $40 million of drought insurance it intended to write, not the nearly $400 million in coverage bound by brokers and agents, said Gail Devlin, Chubb's senior vp-investor relations (*BI*, Aug. 8; July 25; July 18). . . .Cork Gully's Peter Mitchell in Bermuda and Michael Jordan in London have been appointed liquidators of the insolvent **Universal Marine Insurance Co. Ltd.** in Bermuda. . . .**Farmers Group Inc.** was negotiating Friday with Batus Inc., a subsidiary of B.A.T. Industries P.L.C., whose buyout offer of $73 per share was set to expire. Meanwhile, the Illinois Insurance Department joined Ohio and Arizona in approving the acquisition. . . .Continental Corp. intends to purchase **Travelers Indemnity Co.'s surety operations** for about $6 million. Travelers' surety operations generated about $50 million in gross written premiums last year. . . .Last weeks' appeal by a small number of claimants of a proposal to create a $2.4 billion trust fund for women injured by A.H. Robins Co.'s **Dalkon Shield** intrauterine device could delay for months any payments to the claimants (*BI*, Aug. 1).

Royal Globe overturned

Continued from page 1

"This is a bellwether case for the insurance industry," he said. "California sent a clear message to the rest of the country that we had gone too far."

"It is great news as far as insurance companies are concerned," agreed Robert Mecherle, claims vp with State Farm Mutual Automobile Insurance Co. of Bloomington, Ill. State Farm is the largest insurer in California.

Plaintiffs attorneys, however, argue that victims have lost a precious remedy that encouraged settlements by insurers.

"I see families that are victims of bad faith whose remedy has been taken away. This is nothing for insurers to crow about," said William Shernoff, partner with Shernoff, Scott & Bidart in Claremont, Calif.

Insurers' relief may only be temporary as plaintiffs attorneys and consumer advocate groups say they will now focus on a California initiative scheduled for the Nov. 8 ballot that would, in effect, reinstate the Royal Globe doctrine.

The proposal, part of a larger initiative, was filed in an effort to codify the Royal Globe doctrine.

In overturning the Royal Globe doctrine, the court said: "developments occurring subsequent to our Royal Globe decision convince us that it was incorrectly decided, and that it has generated and will continue to produce inequitable results, costly multiple litigation, and unnecessary confusion unless we overrule it."

However, the court said all pending cases filed under the Royal Globe doctrine that are based on a court finding that the policyholder was liable may proceed.

The court said an insurer's mere settlement of a claim is not sufficient to maintain a bad faith action citing Royal Globe.

In rejecting the Royal Globe doctrine, the court cited:

- The refusal by courts in 17 other states nationwide to adopt a doctrine similar to the one exposed in Royal Globe.
- The overwhelming scholarly criticism of the 1979 decision.
- The failure of the National Assn. of Insurance Commissioners to develop a model law permitting an individual victim's right-of-action.
- The fact that the California Legislature in the nine years since the Royal Globe doctrine was enacted failed to reaffirm it through legislation.

The court commented that "Royal Globe may tend to encourage unwarranted settlement demands by claimants, and to coerce inflated settlements by insurers seeking to avoid the cost of a second lawsuit and exposure to a bad faith action."

The underlying case involved a 1983 automobile accident that was settled for $1,800 less than the plaintiff's original demand. The plaintiff sued the insurer for allegedly failing to fairly and promptly settle her claim against the policyholder. She sought compensatory damages and $750,000 in punitive damages.

"Under Royal Globe, every case that walked into the office was a potential bad faith claim—but not anymore," said claims adjuster Fred Fisher, president of The Fisher Associates in Torrance, Calif.

"The cost of conducting bad faith litigation in California has had a serious effect on the insurance industry," said Thomas Brunner, an insurance defense attorney with Wiley, Rein & Fielding in Washington, D.C.

Mr. Brunner said the California Supreme Court's decision to reverse Royal Globe "will lead to a more straightforward, balanced approach to legal matters in California." The Royal Globe doctrine "skewed" the law, he said.

As a result, several insurance industry observers say last week's decision should lower premiums in California.

"It could have a substantial effect on costs and could lower premiums," said State Farm's Mr. Mecherle.

"If the insurance industry has been telling the truth about the insurance crisis, then rates should come down," said plaintiffs attorney Mr. Shernoff.

"If the insurance industry is smart, it will respond by lowering premiums," said Mr. Fisher.

However, Royal Oakes, an attorney with Barger & Wolen in Los Angeles who represents insurers in bad faith actions, said, "premium reduction will come from competitive market forces and actuarial factors," not this decision.

Mr. Oakes called the recent decision "a triumph of statutory language over creative, judicial overreaching."

The court said the issue of whether plaintiffs in personal injury cases have a cause of action against defendants' insurers is a matter for the legislature to decide—not the courts.

However, in rescinding the Royal Globe remedy, the court warned: "Our decision is not an invitation to the insurance industry to commit the unfair practices proscribed by the Insurance Code. We urge the insurance commissioner and the courts to continue to enforce the laws forbidding such practices to the full extent consistent with our opinion."

The court noted that the California insurance commissioner can issue cease and desist orders against insurers, assess fines against insurers up to $55,000 and revoke an insurer's license for up to one year for handling a claim in bad faith.

Several insurance industry critics say the Royal Globe recision could lead to deterioration of California insurers' practices.

However, Mr. Oakes said, "Insurance companies are under a microscope. They are heavily regulated and they are still liable for fraud and misconduct" to their policyholders.

In the dissent to the 5-2 ruling, Justice Stanley Mosk, who authored the original Royal Globe ruling, said: "The majority have now replaced Royal Globe with a 'Royal Bonanza' for insurance carriers; i.e., total immunity for unfair and deceptive practices committed on innocent claimants."

Justice Mosk also wrote: "It will be interesting to observe whether this judicial largess causes insurance premiums to decrease or insurance profits to increase." ■

State Farm campaign financing

Continued from page 2

tive campaign in the history of California."

State Farm, the largest contributor to the insurer-led effort, already has paid more than $1.4 million to support the campaign and could give millions more, according to William Shernoff, an attorney with Shernoff, Scott & Bidart in Claremont, Calif., who brought the class-action lawsuit.

"Instead of guarding that money carefully for its insurance operations as promised, State Farm has embarked on an unprecedented and controversial spending spree of alarming proportions designed to influence the electorate regarding opinions, positions and ideological causes that plaintiffs oppose," the lawsuit says.

"There is nothing to prevent State Farm from contributing a lot more to the campaign," said Mr. Shernoff in an interview. "After all, it's other people's money."

The lawsuit, filed on Aug. 15, accuses State Farm of violating the constitutional rights of policyholders by spending policyholder surplus for political purposes that many of the policyholders oppose.

"Mutual insurance companies spend policyholders' money all the time, but this suit brings the issue to the public eye in a dramatic way," said Mr. Shernoff. "Just how far can a mutual insurer go?"

By law, State Farm, as a mutual insurer, is required to return any unneeded surplus to its policyholders in the form of dividends. In fact, State Farm in its policies says its policyholders will "share in the earnings and savings of the companies."

However, by contributing millions of dollars to the initiative campaign, "State Farm has made false and misleading statements" that constitute an unfair and deceptive business practice under the California Insurance Code, the suit alleges.

"State Farm's representations were false and misleading because they implied that all surplus funds would be available to policyholders for the payment of dividends and to protect the safety of the company and would not be squandered on expenditures for political campaigns," the suit says.

In addition, "The policyholders. . . .entrust their premium dollars to State Farm with the understanding that State Farm will manage the money wisely for the benefit of the policyholders' best interest," the suit says, adding that State Farm breached this fiduciary duty by spending money on a campaign that the plaintiffs believe is not in their best interest.

State Farm reported $14 billion in policyholder surplus at year-end 1987, far in excess of most mutual insurers, Mr. Shernoff pointed out.

"Just a small fraction of that astounding accumulated surplus would virtually eliminate State Farm's California automobile insurance problems and make unnecessary their recently reported increase of 7.9% in auto insurance premiums," the suit says.

However, the spokesman from State Farm said the company believes it needs such a large surplus to back up the 50 million policies the giant insurer writes. "It is not excessive," he said.

The lawsuit was brought by longtime State Farm policyholder Benjamin G. Barnes on behalf of all State Farm policyholders. ■

Nicolet to be liquidated

Continued from page 3

zation called for all of the company's property and equipment to be leased to other businesses, explained Ms. Stegemoeller, who is with the Chicago firm of Defrees & Fiske.

48 Insulations has been essentially out of business since the early 1980s and has just been a vehicle for paying asbestos claims, she explained. The company currently has only two employees.

The amount of money to be distributed under the 48 Insulations plan is unclear because the company is litigating with its liability insurers.

Last year, 48 Insulations sued the 21 liability insurers of its parent company, Foster Wheeler Corp., in U.S. Bankruptcy Court in Chicago to obtain primary and excess coverage for the estimated $4 billion in asbestos personal injury claims pending against it. Officials from 48 Insulations contend that the policies issued to Foster Wheeler cover its subsidiaries, including 48 Insulations.

Unlike 48 Insulations, Nicolet is not involved in any insurance litigation and has used all of its available insurance.

The company had approximately $60 million in primary and excess liability coverage that it exhausted in the defense and indemnification of asbestos claims, said Douglas Smillie, Nicolet's bankruptcy attorney.

Nicolet's principal insurers included Reliance Insurance Co. of Philadelphia and Insurance Co. of North America, a unit of CIGNA Corp. in Philadelphia, said Mr. Smillie, who is with Clark, Ladner, Fortenbaugh & Young in Philadelphia.

When Nicolet filed for bankruptcy last year, it cited assets of $2.1 million and liabilities of $751,349, not including the more than 61,000 asbestos bodily injury and property damage claims it faced at the time.

The asbestos claims, which are estimated to seek a minimum of $133 million in damages, were "a significant factor" in the company's decision to liquidate, said Nicolet President Richelle D. Hittinger, who drafted the liquidation proposal. She also said problems with the "general economy" and decreased demand for Nicolet's products were factors in the decision to liquidate.

Nicolet stopped making high-temperature asbestos insulation in 1964, explained Ms. Hittinger. Since that time, the company has been making a variety of products used in the manufacture of pipe wrap, sheet gaskets and laboratory tables, some of which still contain asbestos, she said.

In December 1987, Nicolet closed its Ambler, Pa., plant, said Ms. Hittinger, who would not disclose any present or past sales figures for the privately held company.

According to the bankruptcy court, Nicolet recorded operating losses of $839,732 in the fiscal year ended March 31, 1987, and $1.4 million in the fiscal year ended March 31, 1986.

Under Nicolet's liquidation plan, which the U.S. Bankruptcy Court for the Eastern District of Pennsylvania will review in October, the company's assets are to be sold and the proceeds placed into a fund to pay asbestos bodily injury and property damage claims.

The fund will be split evenly between the asbestos bodily injury and property damage claimants, with payments being made in-full upon approval of the liquidation plan, according to Ms. Hittinger's proposal. About 61,000 claims are pending.

The amount of money to be deposited in the asbestos claims fund will depend on the resolution of two lawsuits involving Nicolet and its parent.

An action brought against Nicolet by the U.S. government for the cleanup of hazardous waste may reduce the size of the fund, while another action filed by creditors against its parent company and sole shareholder, NuNic Inc., may increase the size of the fund.

In the federal suit, the Environmental Protection Agency has charged Nicolet with dumping asbestos at two large waste sites in Ambler, Pa., and is seeking to recover the $299,495 it spent to test and clean up the area.

The EPA says all of the expenses it incurred during the emergency cleanup occurred prior to Nicolet's bankruptcy filing and should be claimed as administrative expenses to be paid before any debts owed by the company to unsecured creditors, including the asbestos claimants.

In the suit against NuNic, a group of Nicolet creditors are attempting to recover money allegedly misappropriated by NuNic from Nicolet. The suit says $3 million in dividends, more than $400,000 in management fees and about $1.4 million in loan repayments were transferred from Nicolet to the holding company in the three years preceding the bankruptcy filing. ■

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Broker results illustrate intense rate competition

By LEONARD M. WILSON

Special to Business Insurance

One close observer opined that rate cutting was as bad as he had seen in a career that spanned three decades. Another suggested that underwriters took a less extreme view and defended rate reductions on the grounds that the increases of 1985 and 1986 were only being rolled back to more realistic levels.

QUARTERLY EARNINGS REPORTS for publicly owned companies present a window of analysis through which to view the progress of the enterprise. Second-quarter results for insurance brokerages portray a scene of steadily deteriorating premium rates in commercial lines of insurance.

The intensity of rate competition is downright surprising. One close observer opined that rate cutting was as bad as he had seen in a career that spanned three decades in insurance brokerage. Another contact suggested that the underwriters took a less extreme view and defended rate reductions on the grounds that the increases of 1985 and 1986 were only being rolled back to more realistic levels.



Mr. Wilson

Whatever the explanation for the pricing behavior in commercial lines, the soft market was very much evident in the revenue comparisons of the publicly owned brokers. We estimate that retail brokerage revenues in the United States rose 2%-3% for the group. There was inevitable variation within one or two brokers doing better than the norm, depending on such factors as the composition of the client base or the rate of expansion in the producer force.

Progress in U.S. commission growth was, for the most part, more feeble than even the lackluster showing in the first quarter. This is clearly a barometer of intensifying rate competition. We estimate that prices probably dropped more than 15% across a broker's full book of business. Slightly higher commission rates might have mitigated the impact of declining rates, and the ability to buy more coverage at lower price rates could have lifted renewal commissions somewhat. Aviation and ocean marine are subject to competitive forces.

New business carried the day, as it has since the market softened. We detect little diminution in the pace of new business. However, with lower rates, an incremental unit of new business generates fewer dollars than a year ago. If we look at the production of the public brokers in the aggregate, gains are still impressive.

Lost business seems to have stabilized, judging by performance in the quarter. We think that brokers have paid more attention to account retention than in recent months. In addition, the decline in insurance costs may have mollified the disgruntled minority of clients still smarting over the steep price hikes of 1985 and 1986.

Domestic reinsurance had already felt the effect of higher retentions as early as the second quarter of last year. Higher retentions betoken ample underwriting capacity at the primary level, as well as a reaction to steep reinsurance costs. Retentions are still hurting reinsurance brokerage comparisons, but now prices are beginning to sink as well. It is possible that as reinsurance gets cheaper buyers will shift to lower retentions, but for now reinsurance brokers appear to be suffering from the worst of both worlds: soft rates and higher retentions.

Commissions from international insurance brokerage at the primary level did not increase much when measured in British pounds or other local currencies. Markets have not softened to the degree of the U.S. experience, but prices apparently are easing some. New business seems a less dynamic factor in sustaining growth.

Reinsurance brokerage generated by London-based operations seems to be facing a three-fold handicap: Less business may be flowing to London due to a reluctance to take on U.S. liability risks, higher retentions are hurting and rates are soft. Operating costs also have been boosted by the rise in the pound against the dollar on a year-over-year basis. This currency-provoked squeeze on profit margins may subside in the second half as a result of a rallying dollar.

Employee benefit consulting once again went counter to the trend in property and casualty commissions. Revenue growth was strong, consistently in the area of 15% or better in most instances. Changing regulations and the ever-greater complexity of benefits lie behind this momentum. In addition, it could be that the public brokers continue to gain market share in the fragmented benefits arena.

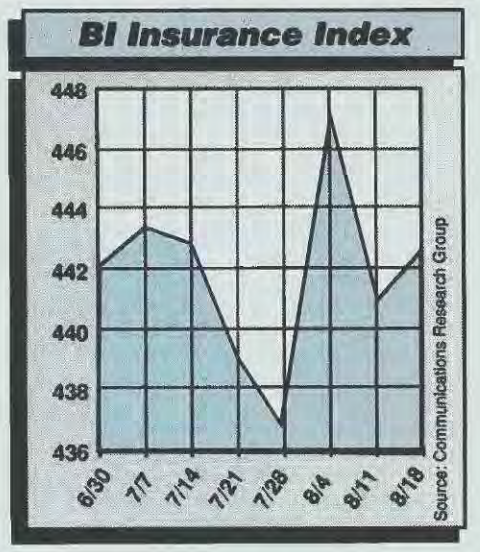
We can generalize about expenses. The public brokers thus far are handling their costs more effectively than in the last down cycle of pricing. Increases in employment costs are modest, and headcounts are stable. Other operating expenses, often a category with a seeming momentum of its own, also rose moderately in the second quarter. Notwithstanding better expense controls, pretax margins edged downward, not at all unexpectedly given the slowing in revenue growth.

Essentially flat second-quarter, per-share comparisons were posted by Marsh & McLennan Cos. Inc., Alexander & Alexander Services Inc. (excluding last year's real estate gain) and Corroon & Black Corp. Arthur J. Gallagher & Co. recorded a decline in earnings in a quarter that is normally quite light and, therefore, does not necessarily foreshadow trends for the rest of the year. Frank B. Hall & Co. Inc. lost $7.1 million in the quarter.

The gathering force of rate reductions will burden upcoming quarters. It is too early to forecast when the soft market will abate despite many theories, one of which centers on the effect of an impending increased tax burden on underwriters' pricing strategies.

Brokerage stocks have held up relatively well in the face of the flattish reports and the growing realization that the interim outlook has darkened. Investor interest in insurance brokerages remains subdued, but some investors are willing to seek out long-term value and await the inevitable realization of those values. It is this school of investing that is probably providing current support for the stocks. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.



Insurance industry stocks halted their downward slide last week, as the *Business Insurance Index* rose 1.8 points to 443 on Aug. 18, from 441.2 on Aug. 11. Advancing issues were led by Farmers Group Inc., up 7.2%; American Indemnity Financial Corp., up 6.7%; Berkshire Hathaway Inc., up 4.8%; Hilb, Rogal & Hamilton Co., up 4.5%; and Lincoln National Corp., up 3.7%. Declining issues were led by Nobel Insurance Ltd., down 8%; Frank B. Hall & Co., down 6.3%; Zenith National Corp., down 4.5%; American Heritage Life Investment Co., down 4%; and SCOR U.S. Corp., down 3.1%. Issues showing the most activity during the period were: Farmers Group Inc., 4.3 million shares traded; Sears, Roebuck & Co. (Allstate) 2.3 million shares traded; and American International Group Inc., 1.6 million shares traded. The *Business Insurance Index* gained a slight 0.4% for the period, performing ahead of the leading market indicators: The Standard & Poor's 500 fell 0.7%; the Dow Jones 30 Industrials dropped 0.6%; and the New York Stock Exchange Composite lost 0.5%.

British Issues

Aug. 18 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commil Union	364	13.9	21.9	5.8	364—355	
Genl Accident	903	10.5	47.9	5.2	909—902	
Gdn Royal Exch	186	14.0	11.0	5.8	188—186	
Royal	397	10.5	26.4	6.5	398—394	
Sun Alliance	968	15.8	43.1	4.3	978—968	
Brokers						
Bradstock	227	12.8	5.0	2.9	227—225	
CE Heath	425	16.2	34.5	8.1	425—422	
Hogg Robinson	165	13.2	9.6	5.7	165—165	
Lloyd Thompson	190	16.4	6.8	3.5	190—190	
PWS Holdings	155	6.5	14.4	9.0	155—153	
Sedgwick Grp	238	14.5	16.4	6.9	238—226	
Sisel Brrl Jones	198	12.2	13.7	6.8	198—197	
Willis Faber	255	13.4	15.4	6.0	255—245	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

AUGUST 18, 1988 — 8/12/88 THRU 8/18/88

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	22.63	1.7	27.5	24.88	17.75	323	1.00	4.4	16.2	3.71	6.10
Baldwin & Lyons Inc.	OTC	16.50	3.1	37.5	16.50	12.00	0	0.20	1.2	6.5	18.31	0.90
Corroon & Black Corp.	NYSE	28.75	-1.3	1.8	34.75	28.00	43	1.08	3.8	4.3	5.43	5.29
Gallagher Arthur J. & Co.	NYSE	17.75	0.0	10.9	18.88	13.88	34	0.48	2.7	12.8	5.16	3.44
Hall Frank B. & Co.	NYSE	3.75	-6.3	30.2	5.50	2.88	74	0.00	0.0	12.8	0.00	N/A
Hilb, Rogal & Hamilton	OTC	11.50	4.5	17.9	12.75	9.75	55	0.00	0.0	12.8	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	54.13	0.9	9.4	58.50	45.25	355	2.40	4.4	13.2	6.74	8.03
Poe & Assoc Inc.	OTC	8.50	0.0	21.4	9.25	6.75	0	0.40	4.7	13.1	0.27	32.08
BROKERS	AVERAGE		0.3	19.6					2.7	11.0		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	27.00	0.9	12.5	29.00	23.50	82	0.36	1.3	6.0	17.63	1.53
Berkshire Hathaway Inc. DEL	OTC	4400.00	4.8	49.2	4525.00	2755.00	202	0.00	0.0	21.4	69.38	11.91
ITT (Hartford Group)	NYSE	47.13	-1.8	4.7	53.38	43.25	1084	1.25	2.7	6.5	52.23	0.90
Sears Roebuck & Co. (Allstate)	NYSE	36.00	0.0	7.0	39.88	32.25	2348	2.00	5.6	9.0	34.74	1.04
CONGLOMERATES	AVERAGE		1.0	18.4					2.4	10.7		
INSURERS/REINSURERS												
Aetna Life & Cas Co.	NYSE	48.38	2.9	6.9	49.88	39.50	1002	2.76	5.7	7.5	53.56	0.90
American General Corp.	NYSE	33.38	1.9	5.1	36.38	27.50	1315	1.40	4.2	9.0	28.04	1.19
Amer Heritage Life Invt	NYSE	24.25	-4.0	0.0	26.00	24.00	1	1.08	4.5	10.6	20.98	1.16
Amer Indty Fin'l Corp.	OTC	12.00	6.7	33.3	11.75	8.25	5	0.56	4.7	46.2	15.26	0.79
American Int'l Group	NYSE	61.25	1.0	2.1	65.38	49.00	1594	0.40	0.7	9.5	33.56	1.83
Aon Corp.	NYSE	26.88	0.5	17.5	27.75	21.88	237	1.28	4.8	9.2	15.13	1.78
Argonaut Group	OTC	44.00	2.3	47.9	49.00	29.50	177	0.00	0.0	7.2	29.19	1.51
AVEMCO Corp.	NYSE	24.13	-0.5	22.9	28.75	17.88	18	0.34	1.4	11.7	7.74	3.12
Belvedere Corp.	AMEX	4.88	2.7	11.4	6.00	4.00	5	0.04	0.8	6.8	7.87	0.62
BMA Corp.	OTC	31.50	-1.6	17.8	36.75	25.50	14	1.20	3.8	29.2	24.45	1.29
Chubb Corp.	NYSE	53.38	-0.7	-4.5	63.38	51.25	230	2.16	4.0	6.2	46.13	1.16
CIGNA Corp.	NYSE	49.00	2.6	11.7	51.88	42.75	793	2.96	6.0	7.9	49.19	1.00
CNA Fin'l Corp.	NYSE	53.25	-0.2	-4.3	64.25	51.00	110	0.00	0.0	7.9	46.40	1.15
Continental Corp.	NYSE	40.38	0.0	4.2	41.63	34.75	491	2.60	6.4	8.2	42.10	0.96
Durham Corp.	OTC	33.25	1.5	54.7	36.25	21.50	10	0.92	2.8	31.4	26.00	1.28
Farmers Group Inc.	OTC	67.25	7.2	67.1	67.63	40.50	4287	1.44	2.1	16.0	22.02	3.05
Fireman's Fund Corp.	NYSE	31.13	0.4	19.7	33.50	25.75	280	0.50	1.6	11.0	26.17	1.19
Forum Re Group	OTC	2.63	0.0	-22.2	4.00	2.63	0	0.00	0.0	4.5	2.58	1.02
Fremont Gen Corp.	OTC	10.50	0.0	9.0	13.50	8.75	607	0.60	5.7	4.5	16.24	0.65
General Re Corp.	NYSE	54.50	2.6	-2.5	57.38	45.50	860	1.20	2.2	11.7	26.21	2.08
Home Group Inc.	NYSE	12.25	2.1	3.1	14.38	11.50	111	0.20	1.6	2.9	17.75	0.69
Hanover Ins Co.	OTC	27.25	0.9	17.2	27.75	20.50	32	0.36	1.3	5.7	25.10	1.09
Harleysville Group Inc.	OTC	15.63	1.6	19.1	16.38	13.38	23	0.40	2.6	6.7	16.65	0.94
Hartford Steam Boiler Insp	OTC	30.50	-0.8	32.6	32.75	22.50	145	1.20	3.9	11.0	10.65	2.86
Kans City Life Ins	OTC	31.25	0.0	19.0	31.25	25.25	0	0.00	0.0	11.0	0.00	N/A
Kemper Corp.	OTC	25.25	0.0	23.2	27.50	20.75	205	0.72	2.9	7.9	26.50	0.95
Lawrence Ins. Group	AMEX	11.00	1.1	144.4	11.63	4.50	2	0.21	1.9	18.0	2.90	3.79
Liberty Corp. S.C.	NYSE	39.00	2.0	9.9	47.25	34.50	13	0.80	2.1	13.8	17.40	2.24
Lincoln Nat'l Corp.	NYSE	52.00	3.7	29.6	53.00	40.25	392	2.36	4.5	10.1	36.62	1.42
NAC Re Corp.	OTC	26.13	0.5	47.2	27.50	18.50	27	0.00	0.0	13.3	19.92	1.31
Nobel Ins Ltd.	OTC	5.75	-8.0	-34.3	9.50	4.50	17	0.44	7.7	27.4	9.37	0.61
Northwestern Nat'l Life	OTC	29.50	-1.3	28.9	30.38	22.63	212	1.12	3.8	6.9	35.05	0.84
Ohio Cas Corp.	OTC	35.00	-1.4	-3.4	38.25	32.25	39	1.88	5.4	7.0	27.86	1.26
Old Rep Int'l Corp.	OTC	24.50	0.5	22.5	25.88	19.13	212	0.74	3.0	5.8	27.82	0.88
Orion Cap Corp.	NYSE	15.00	-2.5	11.1	17.63	13.13	28	0.76	5.1	4.8	9.34	1.61
Phoenix Re Corp.	OTC	8.75	-1.5	34.6	9.50	6.75	56	0.00	0.0	5.1	11.08	0.79
Protective Life Corp.	OTC	13.75	0.0	12.2	15.13	12.25	109	0.70	5.1	14.9	17.25	0.80
Re Capital Corp.	AMEX	9.25	-1.4	-11.9	11.75	9.13	30	0.00	0.0	28.9	11.49	0.81
Provident Life & Acc Ins Co.	OTC	23.13	2.8	48.0	23.13	15.63	337	0.84	3.6	50.3	27.45	0.84
St. Paul Cos. Inc.	OTC	41.50	-1.2	-9.8	51.00	38.25	1004	2.00	4.8	5.9	35.83	1.16
SAFECO Corp.	OTC	24.75	1.0	-10.8	30.00	22.75	402	1.08	4.4	7.6	21.39	1.16
SCOR US Corp.	NYSE	7.75	-3.1	-16.2	9.50	6.63	30	0.10	1.3	5.4	9.39	0.83
Seibels Bruce Group Inc.	OTC	13.00	0.0	15.6	14.25	11.00	77	0.80	6.2	8.7	12.51	1.04
Selective Ins Group Inc.	OTC	25.25	-1.0	32.9	26.25	19.25	66	1.24	4.9	5.7	19.52	1.29
Statesman Group Inc.	OTC	3.44	0.0	-26.7	5.56	3.44	9	0.05	1.5	5.7	3.48	0.99
Tokio Marine & Fire Ins	OTC	75.50	2.7	14.6	85.88	63.25	34	0.22	0.3	67.4	0.00	N/A
Torchmark Corp.	NYSE	32.25	2.0	31.6	33.50	24.50	251	1.20	3.7	10.2	12.24	2.63
Transamerica Corp.	NYSE	33.50	0.8	12.6	36.75	29.75	294	1.84	5.5	7.0	24.94	1.34
Travelers Corp.	NYSE	34.00	-2.9	-3.2	40.00	33.00	1392	2.40	7.1	11.7	45.28	0.75
Trenwick Group Inc.	OTC	13.25	0.0	29.3	13.50	9.75	11	0.16	1.2	10.3	15.41	0.86
United Fire & Cas Co.	OTC	26.50	1.9	1.9	27.00	24.00	34	1.08	4.1	4.8	22.56	1.17
United States Fid & Gty	NYSE	30.50	1.7	7.0	34.38	28.88	1294	2.64	8.7	7.6	19.53	1.56
UNUM Corp.	NYSE	24.50	0.5	32.4	25.00	17.88	263	0.48	2.0	11.1	28.53	0.86
USLIFE Corp.	NYSE	38.38	2.3	34.7	40.13	28.00	459	1.28	3.3	9.9	46.77	0.82
Washington Nat'l Corp.	NYSE	27.50	0.4	15.2	28.75	24.00	16	1.08	3.9	12.8	32.33	0.85
Zenith Nat'l Ins Corp.	NYSE	18.38	-4.5	22.5	23.88	15.00	110	0.80	4.4	8.8	12.53	1.47
INSURERS/REINSURERS	AVERAGE		0.4	16.7					3.3	12.9		
ALL COMPANIES	AVERAGE		0.5	17.1					3.1	12.6		

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